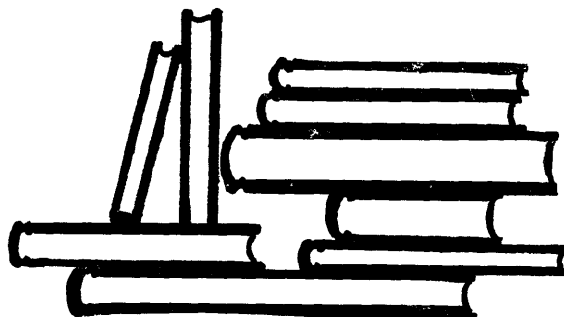


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REHABILITATION OF THE DRUG ABUSER

NINTH INSTITUTE ON
REHABILITATION SERVICES



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Vocational Rehabilitation

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Vocational Rehabilitation

A Report from the Study Group on Rehabilitation
of the
DRUG ABUSER

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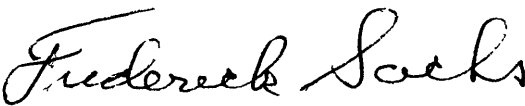
U. S. Department of Health, Education, and Welfare
Social and Rehabilitation Service
Rehabilitation Services Administration
Washington, D. C. 20201

The materials in this publication do not necessarily represent the official views of the Rehabilitation Services Administration nor of State vocational rehabilitation agencies. They do, however, reflect an attempt by State vocational rehabilitation workers to explore a significant aspect of their programs in order to encourage evaluation and stimulate professional growth.

FOREWORD

Problems relating to the uncontrolled use of drugs have reached both national and international proportions with an impact that proverbially leaves us "grasping for straws." Effects upon lives, especially our youth, are so profound, widespread, and often tragic that a nation's resources are challenged in an unprecedented manner. Preventative and ameliorative solutions leave much to be desired, however, our current planning and objectives are directed at developing the knowledge, resources, and methodologies necessary for us to meet this challenge head-on.

This document is the first attempt to pull together some basic information as a guide for rehabilitation staff in serving clients with drug abuse problems. It is not a definitive document on the subject, nor could it be considering the state of the art. There is a growing awareness among "drug abuse" professionals that medical model treatment efforts such as detoxification or maintenance alone are insufficient to return drug abusers to conventional society. Hopefully, the following material will stimulate interest and action regarding the contributions of the vocational rehabilitation program to the overall drug abuse treatment and rehabilitation effort.


607 Edward Newman
Commissioner

PREFACE

Prime Study Group I was assigned the task of preparing a Training Guide on The Rehabilitation of the Drug Abuser, reviewed its original charge, and modified it to include the following: Nature and Extent of Drug Abuse, Evolution of Drug Abuse Legislation, Eligibility and Feasibility, Differential Aspects of Client Study, Staff Attitudes and Counselor Skills, and Service Programming.

The intent of this Training Guide is to present basic information regarding drugs and drug abuse as specifically related to the rehabilitation process and the responsibilities of State DVR agencies. The training material is designed to meet particularly the needs of the rehabilitation counselor working with a client who has a disability of drug abuse.

The outlook of this document is realistic and optimistic, for it is the optimism of a counselor as he confronts realities that will enable the client to respond positively.

Any endeavor, however successful, relies upon the cooperation of many people. Prime Study Group I was fortunate in its membership. The members of Prime Study Group I were Mr. Vernon M. Arrell, Mr. Joseph Carano, Mr. Frederic Clanagan, Mr. John F. Curley, Mr. H. Dorsey Devlin, Dr. George S. Elias, Mr. Philip Kolber (Chairman), Mr. Paul Primavera, Mr. Jerome N. Rubino, Dr. Daniel Sanford, Mr. David Siddle, and Mr. Thomas J. Skelley. Their sincere desire to be of service in this undertaking and the quality and quantity of their efforts were most gratifying. In addition, the committee greatly appreciated the guidance of Les Blankenship and Ray Simmons.

In the preparation of the final draft we were fortunate in having the editorial services of Professor Donald Letendre of Assumption College, the typing skills of Mrs. Mary MacLeod, and over-all secretarial assistance of Miss Esther Johnson of the Institute for Social and Rehabilitation Services at Assumption College who played a crucial role in coordinating the efforts of many people and thus greatly facilitated the work of the Study Group.

Philip Kolber
Chairman
George S. Elias
University Coordinator

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CHAPTER I

NATURE AND EXTENT OF DRUG ABUSE

Nature of Drug Abuse

Drug abuse may be generally defined as the use of a drug for non-medical or non-scientific purposes, with the potentiality of harm to the user or to society. To cover all kinds of drug abuse and to replace the terms addiction and habituation, the World Health Organization, in 1964, selected the term drug dependence. Drug dependence is a state of psychological or physical dependence, or both, on a drug, which results from chronic periodic or continuous use.

In this paper, the terms associated with drug abuse are defined as follows

Addiction "is physical dependence upon a drug. Its scientific definition includes the development of tolerance and withdrawal. As a person develops tolerance he requires larger and larger amounts of the drug to produce the same effect. When use of the addicting drug is stopped abruptly, the period of withdrawal is characterized by such distressing symptoms as vomiting and convulsions. A compulsion to repeat the addicting drug is understandable because the drug temporarily solves one's problems and keeps the withdrawal symptoms away. Drugs other than narcotics can become addicting."¹

Habituation "is the psychological desire to repeat the use of a drug intermittently or continuously because of emotional reasons."²

Psychological dependence "is an attachment to drug use which arises from a drug's ability to satisfy some emotional or personality need of an individual. This attachment does not require a physical dependence, although physical dependence may seem to reinforce psychological dependence."³

Factors Associated with Drug Abuse

No final agreement has been reached as to the precise effects of mind-altering substances on the human body. Although much is known about the effects of drugs with abuse potential, the user himself remains the enigma. Slum environments, easy access to drugs, pushers, and organized crime have been blamed for the problem. Although any of these factors may contribute, no single cause or set of conditions clearly leads to drug dependency, for it occurs in all social and economic classes.

The five major classes of drugs are marijuana, stimulants, sedatives, hallucinogens, and narcotics. The power of the drug varies to a very large extent according to the user, and depends on the amount and manner he uses these substances. The most important general effect characteristic of all mind-altering drugs is loss of self-control, which, in one form or another, leads to self-destructive and anti-social behavior.

All responsible observers tend to agree that much is still unknown about drug abuse, even though the amount of written material is quite large. In this wealth of excellent articles and books, few have brought together the fields of pharmacology, physiology, psychology and sociology in a consistent presentation. Therefore, we strongly urge those who try to comprehend the phenomenon of drug abuse to be wary of oversimplified explanations.

GENERALIZED BEHAVIOR

Certain observations on the effects of the major types of drugs, based largely on knowledge of their chemical composition, may be advanced in spite of our word of caution. (See Chart in Appendix) Certain kinds of noticeable behavior are associated with and can be linked to the major types of drug abuse.

In general, any striking change in the personality of the individual observed should arouse suspicion. The abuser of stimulants may show a marked change from listlessness to excited activity. Conversely, the likely abuser of tranquilizers and barbiturates may change from hyperactivity to sedate, cautious, or even listless behavior. Changes in conduct, such as work attendance, performance, personal appearance and habits, warrant attention. Suspected abusers may wear sunglasses in moderate light or darkness to hide the size of their pupils; they may always wear long sleeves so as to conceal needle marks. The appearance of intoxication without the smell of alcohol is

often the result of barbiturates. A person on stimulants may be nervous and have dilated pupils. The drying effect of these agents on the mucuous membranes may cause halitosis, repeated licking of the lips, and scratching of the nose

Let us now proceed to brief discussions of our five major categories of drugs.

Pharmacological Aspects

MARIJUANA (CANNABIS)

Marijuana, known for nearly 5,000 years, is a drug found in the flowering tops and leaves of the female Indian hemp plant, Cannabis sativa. This plant grows in mild climates throughout the world, especially in Mexico, Africa, India, and the Middle East. It also grows in the United States, where marijuana is also known by a variety of names, such as "pot," "grass," "weed," and "tea," to name but a few. Marijuana can easily be detected when smoked because of its sweetish smell, similar to that of burned rope or dried grasses.

There seems to be substantial agreement that whereas most other drugs have clearly deleterious effects on the abuser, the threat posed by marijuana is less clear-cut. Literature on this subject reveals substantial disagreement even among well-informed scientists and medical practitioners.

The following illustrates this disagreement

"Marijuana, which is not a narcotic, does not cause physical dependence as does heroin or other narcotics. This means that the body does not become dependent on continuing use of the drug. Neither does the body seem to develop a tolerance to the drug which would make larger doses necessary for the same effects. Withdrawal from marijuana does not produce physical sickness."⁴

"There are certain dangers of vivid visions and exhilaration which result from use of marijuana, and abusers become accident prone because of time and space sense disturbance. Dependence (psychic but not physical) leads to anti-social behavior and could be the forerunner of the use of other drugs."⁵

In certain significant areas, however, there is agreement

among reputable and informed authorities.

The following illustrates this agreement

1. Marijuana is universally recognized as a mind-altering drug which in varying degrees and with unpredictable effects produces a state of intoxication sometimes referred to as "euphoria."

2. Marijuana dominates the drug scene on U S. college campuses and is customarily used for the explicit purpose of inducing this state of intoxication.

3 In varying degrees this state of intoxication can cause a lessening of psychomotor coordination and a distortion of the ability to perceive time, distance, and space. These symptoms, however, are not accompanied by a diminution of muscular strength

4. The habitual use of marijuana is particularly prevalent among individuals with marginal personalities who exhibit feelings of inadequacy, anxiety, disaffection, alienation, and frustration, or who suffer from neuroses, psychoses, or other mental disorders

5 Marijuana may have a disinhibiting effect upon the user which tends to aggravate or exaggerate his pre-existing mental state or disposition. Thus, its effects can vary with individuals and on different occasions.

6 Marijuana has no accepted use in modern medicine.

It is impossible to determine the exact extent of marijuana use in the United States. Some health authorities estimate that 4 to 5 million Americans may have used the drug at least once. Other estimates run as high as 20 million. (When one realizes that marijuana must be bought, directly or indirectly, from pushers who can, and sometimes do, put the buyer in touch with hard drugs, it becomes evident that the criminal aura of marijuana is fairly extensive.)

Marijuana dominates the drug scene according to a national survey of college students completed in December 1970 by Gallup Poll. This survey, which included proportional representation of students from private, public, and denominational schools, represented 61 campuses. Current use of marijuana varies according to the backgrounds of students and the type and location of the

college The most frequent user was found to be a male senior or graduate student whose father has a college background and who is studying the social sciences or humanities at an Eastern college. Despite warnings by some medical authorities, the overwhelming majority of student marijuana users think the drug not harmful to their health. It appears that many of the popular myths concerning marijuana will not be dispelled until more convincing evidence of its long-range effects becomes known.

STIMULANTS

The most commonly used stimulants are amphetamine (Benzedrine), dextroamphetamine (Dexedrine), and methamphetamine (Methedrine). All are legitimate drugs, essential to the practice of medicine, legitimate manufacture and distribution are confined to ethical drug channels.

Benzedrine, Dexedrine, and other stimulant drugs do not produce physical dependence as do the narcotics.

"Although the body does not become physically dependent on their continued use, it does develop a tolerance to these drugs so that larger and larger doses are required to feel the effects." ⁶

Medical authorities speak of another kind of dependence, however, in connection with the abuse of stimulants -- "psychological dependence," that is, use can become a habit for mental or emotional reasons.

The American Pharmaceutical Association reports that normal doses of amphetamine produce wakefulness, increased alertness, and a feeling of increased initiative. Intravenous doses produce cocaine-like psychotoxic effects.

Conversely, amphetamines can cause high blood pressure, abnormal heart rhythms, and even heart attacks. It has been reported that teenagers often take them to increase their "nerve." As a result they may behave dangerously. Excess or prolonged usage can cause hallucinations, loss of weight, wakefulness, jumpiness, and dangerous aggressiveness.

Tolerance to large doses is acquired by abusers. Psychic dependence develops but physical dependence does not. There is no characteristic withdrawal syndrome, however, abruptly withdrawing the drug from the heavy abuser can result in a deep and suicidal

depression. Long-term users of amphetamines are usually irritable and unstable and, like other heavy drug abusers, they show varying degrees of social, intellectual, and emotional breakdown.

As for the most adverse psychological effects, stimulants can, in a paranoid individual, inspire violent behavior which may result in homicide.

SEDATIVES

This group includes the barbiturates made from barbituric acid, the most widely abused of the depressants. Drugs in this family are manufactured for medical purposes to relax the central nervous system. All are legally restricted to prescription use only.

The drugs may be taken orally, intravenously, or rectally by the abuser. Usually the appearance of drunkenness without an alcoholic breath indicates barbiturate intoxication. Other symptoms of barbiturate abuse are slurred speech, staggering gait, and mental sluggishness. The person on these drugs may be irritable and antagonistic. Because coordination is affected, the person is prone to stumble and drop things. Often he is bruised and has cigarette burns.

Unfortunately, barbiturates are extremely popular with young people and are often used in combination with alcohol. The combination of these two agents has a synergistic (greater than the sum of both) effect on the central nervous system and, in combination, may cause respiratory depression and death. This same combination may cause the person to vomit, and in a stuporous state to inhale the vomitus, thereby causing a chemical pneumonitis which may be fatal.

Chronic misuse of barbiturates is always accompanied by the development of tolerance and both physical and psychological dependence.

"The tolerance developed to barbiturates is only partial and of such a nature that it may lead to disastrous results. A person indulging in barbiturates develops resistance to their psychic effects but does not develop tolerance to the respiratory depressant or

lethal effect Thus, as the individual constantly increases his dosage in an effort to overcome the resistance to psychic effects, the dosage grows closer to that having lethal effects. Many individuals being unaware of this particular mechanism have accidentally taken overdoses of barbiturates with catastrophic results " 7

Barbiturates are a leading cause of accidental poison deaths in the United States. They are also one of the chief means of suicide. Overdoses, particularly when taken in conjunction with alcohol, result in unconsciousness and death, unless proper medical treatment is promptly given.

Barbiturate intoxication is much more dangerous than alcoholic or narcotic abuse Indeed, some experts consider barbiturate addiction more difficult to cure than a narcotic dependency

HALLUCINOGENS

The illicit drugs that come under this category are LSD-25 (Lysergic acid diethylamide), Mescaline (Peyote), a chemical taken from peyote cactus plant, and Psilocybin, synthesized from Mexican mushrooms

All of these drugs are usually taken orally, but non-intestinal absorption is also possible.

The effects of these drugs are unpredictable They are given the name "hallucinogens" because they may produce hallucinations or illusions affecting the various senses It has been found, as with stimulants and depressants, that the user of hallucinogens may develop a psychological dependence upon these drugs. Unlike depressants, however, hallucinogens do not produce a physical dependence or withdrawal syndrome

Little can be said at this time about two of the hallucinogens Psilocybin and Mescaline Psilocybin is a naturally occurring component of a Mexican mushroom. Mescaline is a naturally occurring alkaloid in the flowering head (button) of the peyote cactus. It has long been used in religious ceremonies by North American Indian tribes As yet, the legal attitude toward this drug is not

altogether clear.

Considerable information is available, however, about LSD and DMT (dimethyltryptamine). The latter is a short-acting hallucinogen found in the seeds of certain plants native to the West Indies and parts of South America. Both are synthetic compounds generally available on the black market as a tablet or sugar cube in which a few drops of liquid chemical have been absorbed.

Current research about the biologic hazards of LSD and other hallucinogenic drugs is considered incomplete. However, the research being carried on by NIMH is wide in scope and activity, NIMH is promoting surveys and epidemiologic studies through basic biochemical and experimental psychopharmacologic research. Hopefully, there will be a better understanding of the biochemical basis of learning and memory at the conclusion of these studies.

The dangers associated with LSD, although seldom noted in the lay press, have been well established. LSD may intensify psychosis, cause inadvertent or intentional suicide, and result in chromosome breakdown. Suicide may be brought on by panic reaction or by deluded behavior, such as attempting to fly out of windows. Some users become stultified to the point of walking into heavy traffic on a highway.

Investigators speak of the phenomenon of recurrence, that is, a reliving of a psychedelic experience, originally induced by LSD, without use of the drug. These recurrences are reported to occur at times of stress and as long as two years after the initial ingestion of LSD.

Another ominous aspect of LSD is that its use without ill effects in no way guarantees exemption from intractable reactions after later uses. Recent articles point out that prolonged bewilderment and fear may strike unexpectedly and last for weeks or months. Such unexpected recurrences are, of course, a disrupting factor in any rehabilitative process.

NARCOTICS

The term narcotic refers generally to opium and drugs made from opium, such as heroin, codeine, and morphine, all widely used as pain-killing drugs. In addition, a number of specially defined synthetic drugs, called "opiates," are also classified as

narcotic drugs under the Federal law Cocaine (made from coca leaves) and marijuana are classified legally, but not chemically, as narcotic drugs

These drugs depress the central nervous system to produce marked reduction in sensitivity to pain, and consequently they are some of the most valuable drugs available to physicians

The abuse of narcotic drugs, which dates from ancient times, is today becoming increasingly widespread Under the influence of morphine-like narcotics, the abuser is usually lethargic and indifferent to his environment and personal situation When the abuser of a narcotic becomes addicted, his body requires repeated and larger doses of the drug This happens because the body develops a tolerance for the drug

One of the signs of heroin addiction is that withdrawal symptoms may develop Characteristically, they may include nervousness, anxiety, sleeplessness, yawning, running eyes and nose, sweating, enlargement of the pupils, increase in breathing rate, hot and cold flashes, to list a few The intensity of withdrawal symptoms varies with the degree of physical dependence and the amount of drug customarily used Authorities state that symptoms begin about 8 to 12 hours after the last dose and that they increase in intensity and reach a peak in 36 to 72 hours At this point the symptoms of withdrawal gradually diminish over the next 5 to 10 days, but insomnia, nervousness, and muscle aches and pains may last for several weeks

Although the possibility of death from an overdose of narcotics is an everpresent danger, the harmful effects to the addict are usually indirect He is usually preoccupied with the technicalities of drug taking and with getting a continued supply. This prevents the addict from continuing either his education or his job. He neglects his health, and as a result his life may be shortened He is usually in trouble with his family and almost always in trouble with the law

Under the Federal law some preparations containing small amounts of narcotic drugs may be sold without a prescription. However, exempt narcotics must be sold in limited quantities, and the pharmacist selling these exempt preparations must have a Federal narcotic stamp. Some of these exempt narcotics are paregoric and certain cough mixtures While many of the exempt

cough mixtures containing codeine have been abused, they are reasonably safe and free of addiction potential when used as directed.

Heroin, by contrast, is highly dangerous

"In the realm of drug abuse probably no substance produces greater psychological dependency and, with few exceptions, greater physical dependency and tolerance than heroin. Once the young initiate has experienced the effects of heroin, his psychological dependency develops extremely rapidly and he is willing to commit any act in order to obtain his drug. The rate of development of the psychological and physical dependency does not depend so much on the duration of use but rather on the quantity of drug and the continuity of administration. He also soon finds that he develops tolerance quickly and the quantity of drug that he needs each day increases rapidly. In a short period of time he realizes that if he does not receive heroin or a similar agent at given time intervals, he undergoes a severe withdrawal reaction. As his need for the drug increases, he finds that he is no longer able to work and must devote all of his time to various methods for obtaining money to pay for his heroin. In a relatively short period he finds that regardless of how much drug he injects, he is unable to attain the initial so called 'high' that he may have had originally and realizes that he is taking the drug only to satisfy his psychological and physical dependency " 8

Heroin may be administered by any one of these three methods by snuffing the powder into the nostrils, by an injection of the substance into the skin or "skin-popping," or by injecting the drug into a vein or "mainlining."

Heroin is mixed with any one of the following substances milk-sugar (Lactose), quinine, benita, or procaine (a local anesthetic). The combination of heroin and procaine gives rise to a stimulatory feeling of warmth and a "tingling sensation" over the entire body, referred to as a "flash." Since too much procaine may cause the heart to fail or stop, to use it as a dilutant for heroin is extremely dangerous. This same "flash" can be experienced by mixing heroin with cocaine. This is called "speedballing." Since cocaine is expensive, it is less often used than procaine.

It is rare that a person using heroin will change to any other substance while the drug is available. Only as a last resort will he seek one of the hallucinogenic or other type agents.

Psychological Factors Associated with Drug Abuse

In his treatise on the "Pharmacological Principles of Drug Dependency," James E. O'Brien, M.D., says

"When we speak of drug dependency, let us remember that the psychological dependency on drugs is not the result of any specific reaction of the drug itself. There is nothing in these agents which imparts to the brain a desire for more drugs. It is the inadequate personality of the individual and the drug's ability to relieve his tensions and anxiety that lead to dependency. Once he has learned to enjoy the experience and, at least in his mind, reaches the conclusion that the reward justifies the risk, he is a drug dependent person." 9

One cannot divorce the human problems of drug abuse from the scientific and still be well informed. Because of this awareness, the Federal government has moved toward a two-pronged approach of regulation and research. Experience has taught us that we must look beyond the specific problems of the various agents (drugs of abuse) to an understanding of some of the underlying causes of widespread drug use. Whether we wish to admit it or not, we live in a drug-oriented culture. Consequently, there is but one way to get to the root of the drug abuse problem. Let us have regulation,

but at the same time investigate (research) and identify the underlying problems which lead people to choose to distort or ward off reality with drugs.

The behavioral scientists use the term "alienation" to describe the cross-generational conflict epitomized by the youth-coined expression, "Don't trust anyone over 30 " Alienation has been characterized as "rebellion without a cause---rejection without a program---a refusal of what is, without a vision of what should be." ¹⁰ From what we see today, drug abuse by many of our youth is an anti-adult orientation that manifests itself in a number of anti-social behavior patterns. There is defiance of the established conventions and traditional norms. The alienated often show themselves aggressive, overactive, impulsive and headstrong, but not always willing to pay the price when ethical standards of society are broken

The problem of drug abuse cuts across almost every segment of our society. It challenges our values and aspirations, and rouses our fears. In many instances the emotional impact clouds judgment and makes effective communication difficult.

Some adults have preconceived notions about many of our young people. Adults are uncomfortable and defensive about discussing drugs with adolescents, and they immediately become anxious whenever there is evidence of any departure from the preferred ("accepted") life styles and customs of the majority. Consequently, it is very important to keep lines of communication open at all levels

It is important to remember that the above material, which presents an overview of drug abuse information, cannot be definitive because the field of study is relatively new and new understandings are emerging almost daily. It is important, therefore, that the counselor keep abreast of current literature regarding drugs and drug abuse. However, if we are to restore adequate emotional, social and vocational functioning, the most effective preventive and rehabilitative techniques must be developed.

Sociological Aspects

PREVALENCE

As far as can be ascertained from a survey of the litera-

ture, there is no single type of drug use or drug abuser. Drug abuse seems to cut across all ethnic, economic, and social boundaries. All segments of our society appear to be experimenting with drug-taking. "The rich and the poor, the urban and the suburban, the young and the middle aged of both sexes are involved." 11 Millions of persons are exposed to drugs, of course, by reason of medical need, relatively few of these people, however, turn to a life of drugs. It is true that in metropolitan areas there are invariably groups of "hard-core" users and that a large proportion of the young persons who use drugs live in the ghetto areas. Indeed, U. S. Public Health Service reports show that heroin addiction today is found chiefly among young men in ghetto areas. Our law enforcement officers tell us that drugs may be available on street corners in metropolitan areas, however, only a small percentage of the individuals exposed join the ranks of abusers.

The National Institute of Mental Health, through its Center for Studies of Narcotic and Drug Abuse, has long been involved in a broad and comprehensive program of support for narcotic addiction research, training, and treatment.

The incidence of drug abuse in specific areas is often difficult to determine. Because a recent study indicated a significant incidence in New York, particularly New York City, efforts are being made to assist the New York City Health Department in compiling a reliable, up-to-date, unduplicated count of addicts in the city. Research efforts such as these will provide information concerning the specific characteristics of the population that runs the risk of drug abuse.

For the most part, research samples and data collection have focused on populations affiliated with legal and medical agencies (the courts, law enforcement officials, medical facilities, and schools). The abusers who fall outside of the above samples may constitute a larger number than we suspect. Also, their characteristics may differ significantly.

SOCIAL CONSEQUENCES

Drug abuse is rapidly becoming a major health and social issue. In a document such as this, one can only touch upon the gravity of the consequences of drug abuse. The problem has spilled into suburbia and is affecting middle-class youth. As a result,

social and legal norms are being challenged and the public is becoming increasingly aroused. Efforts to locate and control the causes of the behavior, and such programs as rehabilitation, which assist in reducing the consequences of drug abuse, are gaining widespread support in all segments of the population.

Drug abuse may have any number of consequences on an individual's social, as well as his physical, functioning. To protect society from evils of the manufacturer, smuggler, and pusher, we have attempted to effect control through legislation. In some ways these laws have been both beneficial and harmful. Our government has been made aware by an aroused public that research, prevention and innovative treatment now characterize a major portion of the government's effort to cope with the problem of drug abuse. Hopefully, we shall come up with reliable and useful materials to dispel the many prevailing myths.

REFERENCES

1. A Federal Source Book Answers to the Most Frequently Asked Questions About Drug Abuse, Washington, D. C. G.P.O., 1971.
2. Ibid
3. Drug Abuse Escape to Nowhere, Philadelphia, Pa.· Smith, Kline and French Laboratories, Publisher, 1970.
4. "Students and Drug Abuse - Facts About Drugs," Reprint from Today's Education, NEA Journal, March, 1969.
5. "A Guide to Some Drugs Which are Subject to Abuse," Drug Abuse Education, American Pharmaceutical Association, 1969.
6. Ibid.
7. James O'Brien, M.D., Pharmacological Principles of Drug Dependency, Unpublished paper, 1970
8. Ibid.
9. Ibid.
10. Resource Book for Drug Abuse Education, National Clearinghouse for Mental Health Information, 1964
11. Stanley F. Yolles, M.D., Recent Research on Narcotics, LSD, Marijuana, and Other Dangerous Drugs, testimony presented before Congressional committee, October, 1969.

CHAPTER II

EVOLUTION OF DRUG ABUSE LEGISLATION

Early Legislation

The first formal controls on narcotics and dangerous drugs in the United States were instituted on the State and local levels about 1885. The development of the hypodermic syringe, the use of morphine to treat the wounded during the Civil War, opium smoking as introduced by Chinese immigrants, and the widespread availability of patent medicines containing narcotics helped create a population of drug-dependent persons.

In 1909 the first Federal law, "An Act to Prohibit the Importation and Use of Opium for Other than Medicinal Purposes," was passed. The term "medicinal purposes" was not defined, but opium prepared for smoking was specifically excluded. All importation was to be regulated by the Secretary of the Treasury

American representatives to the Hague Convention in 1912 urged other governments to establish systems for the domestic control of narcotic drugs, as well as mandating control of the international market. On the international level, this was the first of a long series of agreements culminating in the "Single Convention" of 1953 at a United Nations Conference. This convention was signed by the United States and became a treaty obligation on June 23, 1953. It replaced eight multilateral treaties and represents an attempt to balance legitimate international trade in various drugs while minimizing illicit traffic. To oversee compliance with its provisions, the convention established the International Narcotics Control Board. The Board, however, has no enforcement powers. Consequently, large quantities of drugs enter the illicit world trade.

Domestically, the Hague Convention provided impetus for what is popularly known as the Harrison Narcotics Act of 1914. Passed in the form of a revenue measure, it mentioned neither addicts nor addiction. It required the registration of persons handling narcotic drugs, the use of special transfer forms, and set nominal fees and excise taxes. The purpose of the Act

seemed to be to make drug distribution a matter of record. No mention was made of denying drugs to addicts or of any treatment of addicts. In regard to interference with medical practice, the act provides

"Nothing contained in this section shall apply -- (a) To the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist, or veterinary surgeon registered under this Act in the course of his professional practice only ..."

U. S. SUPREME COURT DECISIONS

The freedom of a practitioner to treat drug users as he saw fit, however, was repeatedly restricted by Supreme Court decisions (e.g., *Webb v. U.S.*, 249 U.S. 96 (1919), *Jin Fuey Moy v. U.S.* 254 U.S. 189 (1920), and *U.S. v. Behrman*, 258 U.S. 280 (1922)). These decisions convinced doctors that they were risking arrest and prosecution if they gave drugs to addicts in the course of any treatment other than in decreasing doses and in an institutional setting. Because addicts were seldom accepted at hospitals, and outpatient care was seemingly illegal, they were deprived of all access to legal drugs. The Treasury Department, charged with enforcing the Act because it was a tax measure, drew its regulations in accordance with these decisions and their implicit feeling that addiction was not a sickness but rather a willful indulgence meriting punishment and not medical treatment.

The view was somewhat softened by *Linder v. U.S.*, 268 U.S. 5 (1925). The Supreme Court held that a physician acting in good faith and according to fair medical standards may give an addict moderate amounts of drugs for relief of withdrawal symptoms without necessarily violating the law. The Court explicitly stated that addiction was a disease and that addicts were proper subjects for treatment. But this decision had little practical effect, possibly because physicians had been intimidated and did not want to gamble their careers. At any rate, the Supreme Court did not expand its dictum until almost forty years later.

In the case of *Robinson v. California* in 1962, the Supreme Court declared unconstitutional a California statute which made it a crime "to be addicted to the use of narcotics." Under this statute the penalty was at least 90 days in the county jail. The

Court considered this a "cruel and an unusual punishment " It emphasized the disease aspect of addiction, stating "Even one day in prison would be a cruel and unusual punishment for the 'crime' of having a common cold."

The State and Federal legislation which followed this decision largely reflects the necessity of providing medical treatment for what was finally judicially recognized as a medical problem.

LEGISLATION OF THE 1960'S

In 1963 the President's Advisory Commission on Narcotic and Drug Abuse recommended the substitution of civil commitment to treatment facilities in lieu of criminal prosecution. At that time, both California and New York had civil commitment legislation on the books, California having had such a program since 1927.

The Narcotic Addict Rehabilitation Act of 1966 is the most far-reaching Federal response to the need for a medical approach. In Title I it provides, in lieu of prosecution, for the civil commitment of narcotic addicts charged with Federal criminal offenses. In Title II, it permits a court to sentence a convicted narcotic addict to a treatment program, in lieu of imprisonment. In addition, it sets up a treatment program for addicts who are not charged with a criminal offense (Title III). An addict may be committed into this program by a related individual, or he may commit himself. Certain classes of addicts are not eligible for treatment under the Act, for example, addicts charged with or convicted of a crime of violence are not eligible under the first two Titles, respectively. Treatment consists of a period of institutional care followed by a longer period of "on-the-street" aftercare. An addict who relapses to the use of narcotic drugs during the aftercare period may be returned to the treatment facility for further care. For Title I, the treatment period is three years, for Title II, indeterminate but not exceeding ten years or the length of the prison term that could have been imposed for the offense of which the addict stands convicted, whichever is the lesser, and for Title III a maximum of 42 months. Under none of the three Titles may an addict voluntarily withdraw from the program.

The Public Health Service has had a role in the medical treatment of drug abuse problems since 1929, when Congress author-

ized the construction of two hospitals "for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs " One hospital opened in 1935 at Lexington, Kentucky, and the other in 1938 at Fort Worth, Texas It also created within the Office of the Surgeon General of the Public Health Service an administrative division, called the "Narcotics Division," which soon became the Division of Mental Hygiene, and eventually became part of the National Institute of Mental Health The Public Health Service role in drug abuse stems from this legislation, (P L. 672-70th Congress, January 19, 1929), the provisions of which are now part of the Public Health Service Act, Title III This act was amended in 1968 to authorize grants to nonprofit organizations for the construction and initial staffing of narcotic addict treatment facilities

The National Institute of Mental Health supports considerable research on abused drugs, their effects, and methods of treatment It also supports the National Clearinghouse for Drug Abuse Information, which is intended as a national locus for all knowledge of abused drugs and their related problems The Clearinghouse provides information to both private individuals and professionals Much of this material will be computerized for easy access

Historically, Federal drug abuse legislation was developed in response to new knowledge of the abuse potential of certain substances, in recognition of channels of illegal trade, and in response to concerned public opinion In 1922 the Narcotic Drug Import and Export Act was passed, amending the Act of 1909 and establishing administrative mechanisms and penalties to reduce drug traffic In 1924 the commercial manufacture of heroin was outlawed

The Bureau of Narcotics was created in the Treasury Department in 1930 for enforcement activities This Bureau and the Food and Drug Administration's Bureau of Drug Abuse Control were merged into the Bureau of Narcotics and Dangerous Drugs, a Bureau of the Justice Department, in 1968 The Marijuana Tax Act of 1937 imposed an occupational excise tax on marijuana dealers and a transfer tax and it also made provisions to "safeguard the revenue therefrom by registry and recording " The transfer tax was \$100 per ounce of marijuana in transactions to a non-registered person Framed as a revenue measure like the Harrison Act, the tax in this case was set high enough to constitute an outright prohibition rather than simply

to identify traffic in the drug.

Penalties for violation of Federal drug laws have been repeatedly increased. They were increased in 1937, by the Boggs Amendments in 1951 and again by the Narcotic Drugs Control Act of 1956.

The Narcotics Manufacturing Act of 1960 established controls over the manufacturing of all narcotic drugs. A major reason for this act was technological advances which had made possible the development of new narcotic drugs. The "Drug Abuse Control Amendments of 1965" specified the regulation of depressant and stimulant drugs and of hallucinogenic substances.

In addition to the Narcotic Addict Rehabilitation Act of 1966, important Federal legislation concerning the treatment of drug-dependent persons includes the Community Mental Health Centers Act of 1963 and the amendments thereto in 1968. As a result, a variety of services may now be provided drug-dependent persons without uprooting them from their communities.

LEGISLATION OF THE 1970'S

The most recent legislative acts are the Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513) and the Drug Abuse Education Act of 1970 (P.L. 91-527). The purpose of the Comprehensive Drug Abuse Prevention and Control Act of 1970 is:

"To provide increased research into, and prevention of, drug abuse and drug dependence, to provide for treatment and rehabilitation of drug abusers and drug-dependent persons, and to strengthen existing law enforcement authority in the field of drug abuse."

The first Title of this Act liberalizes the language of the Community Mental Health Centers Act to allow services to more people, and it broadens the treatment authority in Public Health Service Hospitals for persons with drug abuse problems. It provides also for education and training activities.

The second Title, the Controlled Substances Act, comprehensively defines and categorizes drugs and substances with

abuse potential, provides rules and regulations concerning the manufacture, distribution and dispensing of controlled substances, and gives schedules of offenses and penalties for violation. Additional Titles deal with administrative and enforcement provisions, including the establishment of a Commission on Marijuana and Drug Abuse, and with the importation and exportation of controlled substances and the concomitant adjustments in revenue laws.

The Drug Abuse Education Act of 1970 authorizes the "Secretary of Health, Education and Welfare to make grants to conduct special educational programs and activities concerning the use of drugs and for other related educational purposes."

The projects authorized under the Act may encompass (1) the development of curricula on the use and abuse of drugs, (2) testing the effectiveness of such curricula, and (3) the dissemination of curricular materials and other significant information regarding the use and abuse of drugs to public and private elementary, secondary, adult, and community education programs.

This overview of drug abuse legislation is intended to illustrate societal attitudes from the punitive level to the rehabilitative to the preventative. It is important for the counselor to keep abreast of current legislation, for the evolutionary process in drug abuse legislation has accelerated rapidly.

CHAPTER III

ELIGIBILITY AND FEASIBILITY

Federal Regulations

Eligibility and feasibility considerations for persons with a drug abuse problem who are seeking State rehabilitation services must begin with the Vocational Rehabilitation Act and the current regulations pertaining to the Act.

In section 401 30, the Federal Regulations state the following general provisions for eligibility

"The State plan shall provide that eligibility requirements will be applied by the State agency or local rehabilitation agency without regard to sex, race, creed, color, or natural origin of the individual. The State plan shall further provide that no group of individuals shall be excluded or found ineligible solely on the basis of their type of disability. In addition, the State plan shall specify that no upper or lower age limit will be established which will, in and of itself, result in a finding of ineligibility for any handicapped individual who otherwise meets the three basic eligibility requirements . ."

In the same section, the basic conditions of eligibility are specified as follows

- 1 The presence of a physical or mental disability.
2. The existence of a substantial handicap to employment.

- 3 A reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation.

The regulations, however, give the State rehabilitation counselor further latitude in the eligibility process with the use of the extended evaluation provision which essentially asserts that, if the first two basic conditions exist but the counselor is unable to determine the third condition of eligibility, he may provide an extended evaluation, including the provision of vocational rehabilitation services. The duration of the extended evaluation period for a handicapped person with a drug abuse problem is not in excess of six months, but if certain other disabling conditions exist, such as mental illness or organic brain damage, the client may be eligible for an extended evaluation not in excess of eighteen months.

Physical or Mental Handicap

Both the general and basic conditions of eligibility focus on the disabled person. In the Federal regulations a physical or mental disability is defined as

"a physical or mental condition which materially limits, contributes to limiting or, if not corrected, will probably result in limiting an individual's activities or functioning. It includes behavioral disorders characterized by a pattern of deviant social behavior or impaired ability to carry out normal relationships with family and community which may result from vocational, educational, cultural, social, environmental, or other factors."

Drug abuse frequently is a multi-disabling condition which may cause dependency, endanger health, and strain personal relationships. It is also a problem because of a frequent negative

attitude on the part of the general public. The drug abuser is commonly seen as a socially unacceptable individual with questionable motivation. Drug abuse is also a possible environmental problem, frequently associated with the ghetto. Poor social conditions and the availability of abusive drugs make the ghetto a haven for drug users and drug pushers. Drug abuse, however, is not exclusive to the ghetto. The prime reason for drug abuse appears to be within the individual. The marginal functioning individual, who is unstable, easily frustrated, immature, and emotionally depressed, is an easy prey for drug abuse. Studies of various forms of drug abuse indicate that a majority of drug abusers have some emotional disorder, usually a personality disturbance.

Substantial Handicap to Employment

With a complete understanding of the wide range of factors which may influence or cause drug abuse, the counselor must establish if the client's functional limitations are severe enough to constitute a substantial handicap to employment. He must determine how drug abuse impedes the client's occupational performance by assessing how the client is prevented from obtaining, retaining, or preparing for employment in accord with his abilities and capacities. Of particular relevance in the determination of the employment handicap is the examination of medical, psychological, vocational, educational, cultural, social, and environmental factors.

Rehabilitation Potential

Having determined that an applicant has a substantial employment handicap, the counselor must establish that there is a reasonable expectation that vocational rehabilitation services, when completed, will lead to the individual's employment.

At the beginning of the eligibility process the counselor determined whether or not the disability and limitations were severe enough to establish a substantial handicap, now he must determine whether or not the limitations are too severe. The counselor must evaluate the potential capacity of the individual to enter eventually into some type of gainful employment. He must decide what type of programs the client needs and when those should be initiated so that he can reasonably be expected to complete successfully the State rehabilitation program. In

some cases, treatment may be required before he begins the State rehabilitation program. This determination is based on the counselor's evaluation of the client's potential capacity to succeed. The counselor must review the pertinent history of the client and evaluate, through counseling, the client's interest, motivation and aptitudes.

Before making a final decision, the counselor may consult with a psychiatrist and/or psychologist. If he is still unable to reach a definitive judgment concerning rehabilitation potential, he may consider the utilization of the extended evaluation provision, as previously described.

CHAPTER IV

DIFFERENTIAL ASPECTS OF CLIENT STUDY· SPECIAL CONSIDERATIONS AND NEEDS

Two large variables are to be noted in the consideration of differences among drug abusers. One is inherent in the nature of the drugs themselves, and the other is inherent in the drug abuser's individual make-up.

The characteristics of such a state (drug dependence) will vary with the agent involved, and these characteristics must always be made clear by designating the particular type of drug dependence in each specific case, for example, drug dependence of morphine type, of barbiturate type, of amphetamine type, etc.

Drug abusers fall into three groups (1) situational abusers, (2) spree abusers, and (3) hard-core abusers. The situational abuser employs the drug to cope with certain situations, for example, the student who uses amphetamines to stay awake. The spree abuser employs the drug to escape boredom or to fill an emotional void. The hard-core abuser has passed the experimental stage during which he tries a number of drugs and now has developed a strong dependency on a particular drug, usually heroin. Since pharmacological factors have been discussed earlier, emphasis will be placed upon the "hard-core" drug abuser in contrast to the individual who has been experimenting with various types of drugs over a relatively short period of time and who has not developed as yet strong dependence on any particular drug.

In this discussion the drug abuser's characteristics are broadly grouped under four headings: social, psychological, medical, and vocational---all of these overlap, of course, to some degree.

Social Characteristics of Drug Abusers

Most drug abusers present a history of social disorganization, including the disruption of the employment pattern, family disintegration, disengagement from the community, and rupture of customary social relationships.

Drug abuse resulting from social disorganization is currently found on all socio-economic levels and is associated with social antecedents of alienation, which may stem from broken homes, absence of the father, death of the mother, and from a wide variety of other emotionally-fraught conditions. Feelings of alienation often seem related to efforts to escape from threatening surroundings or to fill an emotional void.

Generally, drug abuse is initiated in adolescence. Confronted with few easily attainable goals, teenagers and those entering adulthood feel strongly the need for identity. As a consequence, drugs may appear to many adolescents as a passport to friendship, status, and membership in the in-group.

Although an important factor in determining the use of drugs is their availability, possibly of almost equal importance are the social factors of custom, fashion, and fad. These play a large role in initial experimentation, in the epidemic spread of drugs in a community, and in their persistent presence.

Closely associated with custom, fashion, and fad is the adoption of the drug-culture attitudes and behavior of the drug abuser's associates. It is not uncommon for drug abusers to adopt the habits of other drug abusers who serve as models for observational learning. Individual and group contacts reenforce these tendencies to avoid and run away from difficulties (not connected with obtaining drugs), to disregard cultural expectations, to turn night into day and to regulate activity by the need for drugs, to exhibit suspicion and hostility and to outwit and "con" persons with whom they deal. These characteristics tend to be the outgrowth of past disappointments and a history of failures.

In pointing out some of the social characteristics which are most prominent and help differentiate the drug abuser, it is important to realize that the drug abuser is pulled between two worlds the life of the non-user, which appeals because of

its obvious comforts and degree of community acceptability, and the life of the drug abuser with its transitory intense delights followed by a feeling of utter despair. Thus, the drug abuser develops attitudes of ambivalence and may attempt to live in both worlds at once.

Society has generally developed a negative attitude toward drug abusers, frequently resulting from the association of addiction with criminality and a presumption of psychosocial deterioration from continued drug usage. A spiral of rejection has occurred. There has been a tendency on the part of society, as well as of professionals, to view the drug abusers with disapproval, anti-social behavior has reinforced this negative attitude. The consequence is that the addict has become more hostile and alienated

Interrupting this spiral of rejection by effective application of our increased knowledge and more sophisticated technology represents a major challenge to vocational rehabilitation agencies. While drug abuse is a serious social disease, our more recent experience indicates that the abuser can be rehabilitated.

Psychological Characteristics of Drug Abusers

When measured by conventional professional instruments, most drug abusers tend to function below their full potential because of extraneous factors which distort the testing situation. In many instances the evaluation is accompanied by high anxiety which depresses scores and ratings. At other times the drug abuser may look upon the evaluation with suspicion and doubt. The result is a desultory performance which, in turn, reflects his inherent distrust of, and sometimes even contempt for, established evaluative procedures.

Feelings of self-devaluation are common among drug abusers. Very often, these feelings find expression in anticipation of disappointment, expectation of failure, the drug abuser's view that he lacks the ability to compete in business and social activity. The presence of these feelings explains why the drug abuser comes late to an appointment or even misses completely.

In a rehabilitation program the drug abuser sometimes

speaks of the period when he maintained his habit as "wasted years," because it represents lack of accomplishment and failure to acquire useful skills. He realizes that he had focused on the narrow objective of purchasing drugs at a time when many of his age-peers were achieving mastery over a wide range of problems. As a result, he has failed to acquire an arsenal of knowledge and skills as well as the self-confidence that increases with every successful achievement. In other words, he did not develop adequate ways of coping with day-to-day challenges. Consequently, he tends to react rigidly and without variability of response, and his behavior repertoire is limited.

Many drug abusers tend to expect immediate gratification and achievement in any plan entered upon. In planning or in initiating a program, they often find it difficult to substitute remote objectives for their present satisfactions. Theoretically, there may be some connection between the immediate satisfaction demanded by many drug users and the rapid gratification obtained whenever they take drugs.

The outstanding characteristic of the drug abuser's life is "crisis" generated by his intense and periodic need for drugs. Indeed, if he must support his drug "habit" by illegal means, this behavior tends to re-enforce his life style until it may become habitual and, indeed, if his affairs run too smoothly, he may feel somewhat uncomfortable. The implication for working with the drug abuser is that he may need considerable adjustment to fit into a non-crisis routine such as day-to-day school or work on the job.

Medical Characteristics of Drug Abusers

Two types of problems require medical expertise (1) those related directly to drugs, such as withdrawal and overdose, and (2) those indirectly related, such as care and supervision of the drug abuser's health. It is generally agreed that medical withdrawal from drugs does not present much of a problem. On the other hand, adequate health care and supervision are frequently difficult due to the very poor relationships which drug abusers have with the medical profession.

Often drug abusers conclude that medical care is not important for them. This attitude stems from their primary preoccupation with drugs, their lack of easily discernible health problems, their youth and immaturity, or their poor personal relationships with doctors and physicians who have refused them prescriptions for narcotics. Nevertheless, the drug abuser is subject to a wide variety of diseases as a result of his exposure over long periods of time to unsanitary conditions, his failure to engage in elementary health precautions, his lack of adequate and proper nutrition, and the misuse of his body by hasty injections with unsterilized needles.

Respiratory problems are probably rated the number-one health problem among drug abusers. Most prevalent among the respiratory diseases are chronic lung disease, obstructive and ventilatory abnormalities, and tuberculosis.

A second large area of illness among drug abusers is liver disease or an ailment related in some way to the liver. Many drug abusers have hepatitis or some variant of it. Illnesses resulting from excessive use of alcohol are another problem area among drug abusers. Those who are abstaining from the use of heroin, either through methadone maintenance or some other means, sometimes resort to alcohol as a "crutch" or substitute. Alcohol is cheap, easily available, legal, and socially acceptable.

A physician made the following observation to those seeking information Medical programs which remove the craving for heroin (or block it) but send the drug abuser back into his previous neighborhood, expose him to the problems of living which he still must cope with adequate housing, management of health, and employment.

Deterioration in health and in personal and social adjustment begins when the drug abuser has excessive time on his hands and when he starts to use other drugs such as alcohol and amphetamines.

The most prevalent diseases in addition to those mentioned above, appear to be the following (not arranged in order of frequency) endocarditis, dermatologic difficulties, multiple

infections, skin breakdowns, abscesses due to unsterilized needles, dental problems, gastrointestinal complaints, and edema due to injury to lymphatics and venous system

Vocational Characteristics of Drug Abusers

Vocational counseling is essential for the full rehabilitation of the drug abuser. Whether he is pursuing a rehabilitation program with such aids as methadone or cyclazocine, or whether he has been able to give up drugs without such help, vocational counseling is required for him as much as it is for other disabled persons. Except in the most unusual circumstances, he will need help in securing employment that is suitable, even though he remains off the street as far as drugs are concerned. Accordingly, attention should be given to all characteristics which will contribute to suitable placement, that is, not only to his abilities and past experience, but also to his goals, aspirations, plans and proposals for achieving them.

In our earlier experience, the drug abuser often presented a history which lacked sustained achievement in middle-class cultural pursuits and included failure to complete high school and inability to obtain steady, skilled employment. He frequently lacked close familial attachments, and was often the product of a broken home. He might have developed a pattern of anti-social behavior leading to arrest, conviction, and incarceration.

More recent experience indicates that drug abuse in industry now has emerged as a problem of considerable magnitude, which continues to grow. Except for a few of the larger employers, industry has not attempted to establish personnel policies, medical practices, or administrative procedures for control of the problem. Some employers report that when the user is discovered and confronted with this problem, he drops out of employment. As a result, the rehabilitation counselor may find himself increasingly involved with a somewhat more sophisticated drug abuse client who may offer a recent attachment to the labor market and a broader array of skills and aptitudes. Upon completion of vocational rehabilitation services, and with the assurances of the State agency, the last employer may well consider the re-employment of such an individual.

A COUNSELING APPROACH

At the very beginning the counselor should direct attention to the stated reason for the drug abuser's coming to him, what help he can expect to obtain, and what first steps should be taken to achieve his declared goals. The counselor should utilize the interviewing session as an opportunity to convey his respect for the self-actualization potential of the client, and to manifest sincere interest in him as an individual, so as to capitalize on motivation for vocational achievement.

There is no implication in what has been said that the counselor must accept the stated vocational goals of the drug abuser. More than likely these goals may be completely unrealistic because of the drug abuser's lack of understanding of his own abilities and his lack of knowledge of the occupation he has selected. The counselor, however, must work with these choices, he must point out specifically their unsuitability and the reasons why they are unfeasible, if such is the case, and encourage the drug abuser to discuss and seek alternatives.

Attitudes of complete dependence on the counselor may be exhibited by the drug abuser. Having come or been sent to the counselor for help, he may expect the counselor to choose the most suitable goal or training program for him. He asks, "Isn't that what the counselor is supposed to do?" Rather, the counselor works with the drug abuser in the situation which presents itself and helps him to assume responsibility for choices and for making arrangements to implement them.

The drug abuser is most often accustomed to talking about his drug experiences (he may enjoy doing so) and he will probably expect the counselor to offer to "cure" him of his drug dependency. Instead, the counselor should make the drug abuser understand that abstention from drug use, and not the "cure" of the individual's drug dependency, is the initial concern and that their mutual interest is primarily in gaining satisfactory employment.

Many times the drug abuser looks upon vocational counseling as simply the selection of an occupation, believing that once a choice has been made, he can easily obtain his chosen job. The question frequently raised is, "When can I begin?", or if training is required, "Can I start school tomorrow, and how long do I

need to go?"

The drug abuser is frequently unaware of the need for readiness for employment. Whereas he has some grasp of the need to develop specific skills, he has little comprehension of the need to acquire acceptable work habits, to change his attitude and self-image, and to increase his self-confidence

The drug abuser with limited work history is very often faced with difficulty in securing employment, even after he has completed months of training and has learned the necessary skills and "know-how ". The counselor finds that, similar to other clients with limited work history, the drug abuser may lack rudimentary knowledge of how to seek a job, how to dress for and act in an employment interview, and how to fill out an application form. Often he has meager work experience, with long non-employment intervals which must in some way be accounted for. Generally he has a police record in addition to a drug history, and fears his prospective employer's reaction to both of these. Some of his fears are real and some imagined. In terms of the real, the counselor and the client should be aware of any limitations and constraints imposed upon possible job opportunities as a consequence of the police record, for example, licensing or bonding

While these factors may not be applicable to the newly emerging group of drug abusers in industry, it is obvious that there are no pat answers to many of the individual problems that are bound to arise. The drug abuser should be aware that certain embarrassing questions will be raised and that these will have to be confronted by him, in many instances with the help of the counselor.

CHAPTER V

STAFF ATTITUDES AND COUNSELOR SKILLS

Positive Factors

Recent work with drug abusers has demonstrated that sizeable numbers, greater than previously estimated, can be rehabilitated. In large measure, the favorable results obtained stem from better understanding of the disability populations, the cooperation of professionals and concerned persons in meeting the client's special needs, the strengthening of the rehabilitation model for service, better client management, and increased availability of facilities and other critical resources.

The counselor who is not closely associated with concerted rehabilitation and medical programs is usually more successful as a participant in a shared attack upon the drug abuser's problem. In an area which benefits from a rich variety of rehabilitation facilities, the counselor often has an opportunity to develop skills and attitudes not otherwise possible.

Ambivalent Attitudes

From the earlier days of skepticism among professional colleagues, disappointments among counselors, and despair or cynicism among the drug abusers themselves, there has been continuing positive growth and development in staff attitudes and counselor skills. Nevertheless, the counselor still finds the drug abuser often has ambivalent feelings toward help, desiring aid but doubtful of the counselor's ability to provide it. The counselor has to deal simultaneously with the drug abuser's current and past fears, his refusal of help, his undependability, and even his attempts to manipulate the worker whom he distrusts. As a result, the counselor may find himself in a dilemma. Should he adopt an attitude of vigilance and suspicion, so as not to be outmaneuvered by his client, and in the counseling session call attention to the client's subterfuges, inaccuracies, mis-

statements and untruths, or should he look upon the drug abuser as a helpless person, who requires more than the usual degree of counselor acceptance and support, because of his feelings of alienation, self-devaluation, and attitudes of general inadequacy?

Counseling Strategies

Faced with alternatives that are extreme, the skilled counselor undoubtedly will choose some intermediate position, which will stress the development of mutual confidence by counselor and drug abuser, so as to allow, on the one hand, for the client's ambivalent feelings, uncertainties and failure to cooperate and, on the other, for the counselor's setting limits and his insistence upon adherence to agreed upon arrangements and understandings. At no time should the counseling relationship descend to an unquestioned acceptance, or rubber-stamped approval, of the drug abuser's plans. The counselor should keep constantly in mind that one of his major objectives is to build a mutual-trust relationship that can be carried over in some degree by the drug abuser to the workaday world.

Willingness on the part of the counselor to deal with what is important to the client at the present time is another means by which he may demonstrate confidence in the drug abuser as a person and an interest in his welfare. This is an effective counseling strategy, particularly with the drug abuser who has been interviewed by specialists on repeated occasions inquiring about his past history and his ultimate goals for the future. The counselor makes a practice of asking about the client's present vocational plans, he concentrates upon the necessary steps to accomplish these, encouraging the drug abuser where the plans are realistic and attainable. On the other hand, the counselor does not refrain from pointing out firmly any impracticalities and irrelevancies. He emphasizes his interest in the drug abuser as a person by limiting the discussion to plans for the immediate future, not for the rest of the client's life.

SPECIAL CONSIDERATIONS

The drug abuser is an individual who needs careful handling, can withstand only slight stress, and requires continuing counselor support during the entire rehabilitation process. Whatever the counselor does and says, he should act

so as to bolster the drug abuser's self-image, showing confidence in him, presenting him with situations where he can be successful and where his success can be recognized, because lack of success will re-enforce feelings of inadequacy

The counselor who works successfully with narcotic addicts must be honest with them in interpersonal relations and at all times avoid actions and words which to the drug abuser may seem evasive and misleading. In describing situations and conditions to his client, the counselor should elaborate them with particular care, because in so doing he enables the drug abuser to make more realistic choices and, equally important, to assume full responsibility for them. The approach avoids impulsive decision-making, characteristic of the drug abuser.

The suspicion and craftiness which the drug abuser sometimes brings to meetings with the counselor, particularly at the beginning of their association, must be offset by the counselor's demonstrated genuine concern. Painstakingly he should work out, with the client participating in each step of the process, a vocational program from the initial phases to the end, making sure that the client understands each part and its relation to all the other parts. An essential characteristic of the counselor working with drug abusers is patience, the ability to capitalize on the client's motivation but, at the same time, to restrain the drug abuser's impetuosity in choosing an occupation and in making hasty and unfounded long-term decisions.

Above all, since the drug abuser in his style of life pays little attention to conventional habits and expectations, the counselor should explain the necessity for adequate and extensive job preparation and, where needed, for developing skills and attitudes to meet job requirements.

"OPEN DOOR" POLICY

Panic often occurs when the drug abuser moves from the sheltering confines of the training program into the seemingly hostile setting of searching for employment or actually starting to work on the job. This may be just the time when the counselor needs to give the drug abuser more encouragement and greater confidence. Again, if the drug abuser has been working for a

few weeks and loses his job, whether through his own fault or not, the counselor needs to come to his early assistance with help and support such as might not be required for a person with greater inner resources. Even when the client's case may officially be closed and no longer active in the case load, the drug abuser needs the knowledge that the counselor's door is still open to him at any time for help and support. He should feel confident that in times of anxiety he can turn to the counselor, to whom he has ready access.

During the transition period from searching for employment to becoming firmly and securely established on a job, the counselor should, as part of his counseling skills, encourage the drug abuser to utilize two other means of support and relief of anxiety

- 1 He should urge the client to maintain or establish contact with the rehabilitation referring agency outpatient departments, rehabilitation center, or probation officer, to whom the client may turn in case of need
2. The counselor should pave the way, if possible, for the client in times of anxiety and need to approach his employer or immediate supervisor for reassurance and help.

Clearly, these means of support will have to be adjusted to individual needs. Nevertheless, mere awareness on the part of the drug abuser that the "open door" policy is in effect may provide him, however remotely, with the support needed to maintain self-control and take the next positive step in the direction of self-responsibility.

CHAPTER VI

SERVICE PROGRAMMING

This chapter focuses on the concepts and principles of service programming and includes a description of the components of comprehensive service.

Relevant Considerations

AGENCY CLIMATE

A fundamental factor that influences counselor service is the agency climate. In discussing community-based rehabilitation programs for the drug abuser, Wiener refers to such a climate as having the following attributes "Hopefulness rather than defeatism, it is necessary that a little optimism be engendered in the field, tempered with a measure of reality....Patience, it is essential that the impression not be given that positive results will appear overnight" ¹ and recognition of the need for "pioneering effort." He adds that "Knowledge and skills are not always equal to the task in all its complexities and that failure will occur." ²

It should be noted that there is no imputation of absence of service-promoting qualities. Rather, it is suggested that these attributes be strengthened.

SERVICE-PROMOTING QUALITIES

Agency Administration should explicitly recognize the severity of the disability and the problematic outcome for a segment of the drug abuse population. In spite of these limitations, adequate allocations of staff time and money must be assured. Essential, too, is administrative endorsement of pioneering effort on the part of counselors, that is, liberality in accepting clients and in testing innovative service approaches. These elements, together with training programs to enhance counselor competencies, foster an essential spirit of service optimism.

COUNSELOR CHARACTERISTICS

The counselor is a critically important agent in the

process. Diskind,³ in his description of the program of the New York State Narcotic Treatment Bureau, indicates greater treatment effectiveness with personnel characterized by "high frustration level, infinite patience and ability to form sound professional relationships with clients because of an outgoing warm personality." It is essential for the counselor to be aware of his own feelings and behavior toward drug abusers, this whole area of the counselor's acceptance of, and empathy for, the drug abuser is one that should be considered in the counselor training program.

COMPREHENSIVE SERVICE STRATEGIES

Since the concept of the holistic is integral to the philosophy and practice of State VR Agencies, it may be superfluous in this context to repeat the crucial importance of treating the whole man. The literature reasserts the interrelatedness of the physical, psychological, social, and vocational elements within the life situation of the drug abuser and the urgent need to provide service in all areas of dysfunctioning. The central importance of comprehensive service, then, merits reemphasis.

In its service process, the State VR Agency must attend to the client's discernible progress and his eventual gainful employment. The counselor, within his responsibility for discretionary use of case service monies and because of the focus on vocational placement, needs a method for appraising on a continuing basis the client's motivation and progress. Such appraisal is necessary because the drug abuser's adjustment is often tenuous. Perhaps the service process can so be structured to provide an ongoing appraisal of progress consistent with the counselor's responsibility to the agency and also accommodate the client's needs within the agency's expectations. The method of carefully defined interim goals is related to a chain of service elements. The strategy is to make the provision of some subsequent services contingent upon completion of a prior service. A progression of services, for example, from pre-vocational training, through vocational training, and culminating in placement assistance can thus be structured and "contracted" between the client and counselor.

Obviously, this strategy will not be applicable to

many individuals who need immediate gratification. Conversely, there is some opinion that the experience of set limits is a necessary developmental learning experience for such individuals and that there is an abdication of professional responsibility in not imposing a distinct structure. Within this latter orientation, the "contract," provided it is viewed by the client as rewarding, has the potential of serving both the client's needs and the counselor's monitoring function. This suggested approach does not advocate a "lock-step" operation. Rather, there is a diversity of services and options within the several service stages of the rehabilitation process. The client chooses within these options but is obliged to pursue activities deriving from service choices.

Historical Background

EARLY CLINICS

In the early part of the century, addiction was viewed solely as a medical problem. Treatment was provided by general practitioners all over the United States. When the Harrison Act was passed in 1914, it no longer was legal for private physicians to disburse narcotics to sustain addiction. As a consequence, thousands of addicts were cut off from their legal supply of drugs. Approximately 44 clinics or narcotic dispensaries were set up between 1919 and 1923 to remedy the situation. Some of these clinics operated only for a few weeks, others for as long as four years. On the whole, the clinics seemed to have no purpose other than the dispensing of drugs to addicts in order to prevent exploitation of the patients by drug peddlers and other underworld figures. The directors of most clinics did not attempt to cure patients of their addiction, but merely to sustain it.

Some beneficial results were claimed from the operation of the clinics. They were supposed to have brought the addict out of hiding and made him accessible to examination and to efforts at rehabilitation. On the other hand, opponents claimed the clinics actually achieved no good results, they maintained that drugs were given out indiscriminately, addicts clustered around clinics, and peddling of narcotics increased. To evaluate the clinics is impossible because of the incomplete nature of the data.

With the closing of the last of the clinics in 1924, medical treatment gave way completely to the dominance of legal efforts at control.

PUBLIC HEALTH SERVICES HOSPITALS

A new era in the treatment of drug abuse started in 1934 with the opening of the Public Health Services Hospital at Lexington, Kentucky, and Fort Worth, Texas. This treatment attempt here was basically a medical model.

These hospitals accept both voluntary patients and those committed on conviction of Federal Narcotic Laws. They have a combined capacity of about 2,500 in-patients. About 40% of the patients at Lexington and Fort Worth are repeaters and, although estimates of the rate of relapse vary considerably, generally authorities agree that the proportion of addicts remaining abstinent for prolonged periods of time has been small

In an attempt to remedy the situation of a high relapse, the National Institution of Mental Health conducted a five-year demonstration program in New York City. From 1957 through 1961, addicts discharged from U. S. Public Health Services Hospital in Lexington, Kentucky, were counseled at the New York City Center and referred to community health and welfare agencies. The Center was established on the premise that increased use of community resources would improve chances for the addict's recovery. The result was that gradually some addicts showed improved general functioning in socialization, greater drive to overcome addiction, and an increase in the intervals of abstinence. But over all, the results were limited

There have been recent attempts to increase the treatment effectiveness of their program, and both Federal hospitals are endeavoring to provide a comprehensive treatment program including gradual drug withdrawal, vocational planning, recreational activity, and some psychotherapy

The Federal Hospitals and other early programs have helped to set the direction of our current treatment efforts. Most of the current drug abuse treatment program may be characterized as community-oriented and are quite different

from the early focus which may be characterized as institutionally-oriented.

Treatment System

DEFINITION

Drug abuse treatment is best understood as a process taking place over a period of time. In the process the patient receives a variety of services provided by staff, located in a network called a "system," which consists of agencies, programs, and facilities. Some of these facilities provide services specifically for the drug abuser, most, however, provide a general range of services which are available to the public and also to the drug patient.

COMPREHENSIVE CARE

The effectiveness of the system for treatment of drug abusers varies greatly. In some jurisdictions no specialized facilities exist for rehabilitating drug-dependent persons. This may be because the general level of health and social services is too low to support special programs for drug treatment, or because mental and public health services are generally available, but with limitations which effectively close them to drug-dependent persons. But all too often, the pressing problem is the lack of communication, cooperation, and coordination among the agencies and facilities involved, thus making it difficult for the patient to receive a coherent pattern of care.

Even in jurisdictions where specialized facilities do exist for treatment and rehabilitation of the drug user, he is still dependent for comprehensive care upon services from a variety of related sources, including mental and public health programs, private and public social service agencies, parole and probation service, and vocational rehabilitation programs.

In many drug abuse treatment programs, it is evident that there are many gaps in the system, for example, when a hospital treats a medical emergency involving an overdose of barbiturates and then releases the patient without referral for any further treatment, or a patient is released from a drug treatment facility for vocational service and is told that there are no openings in the training program and that he must

wait six months.

Individual programs or agencies within the system may be quite good, but the drug user's rehabilitation depends upon the availability of the full range of services and not merely those offered by one agency.

CONTINUUM OF SERVICES

Rehabilitation can then be seen as requiring a continuum of services given by a number of different agencies. Many communities are presently developing organizations which seek to initiate, coordinate, and monitor a comprehensive, area-wide network of collaborative programs. These organizations emphasize the necessity of developing a broad base of community support for planning/programming. They attempt to bring together a variety of services and programs including mental and public health programs, social service programs, parole and probation, police, and vocational rehabilitation programs.

STAGES IN REHABILITATION CONTINUUM

The patient's progress in the rehabilitation continuum may be divided into three stages (1) Intake, (2) Intensive treatment, (3) Aftercare.

1. Intake

The intake stage leads up to and into the treatment system. It is characterized by casefinding, diagnostic evaluation, and referral functions. It may also include medical services for detoxification in case of an emergency.

At the present time, the intake process takes place on a rather haphazard basis. Unfortunately, a great many agencies performing intake functions (for example schools, courts, mental health centers, social service agencies) have only a limited understanding of the programs and facilities available for treating drug-dependent persons.

2 Intensive Treatment

The intensive treatment stage is characterized by the provision of a range of services intended to be therapeutic and rehabilitative. These therapeutic services are designed to identify and modify those characteristics of personality and behavior underlying or contributing to drug abuse, the rehabilitation services are designed to strengthen the patient's capacity for social adjustment and techniques for coping with reality. Needless to say, there are overlaps in rehabilitation and therapeutic services since both are providing services simultaneously. Treatment components include medical service, individual, group and family counseling, education, vocational rehabilitation and training, and therapy led by an ex-addict. The latter is only one of the many illustrative examples that could be included.

Usually treatment is thought of as beginning with inpatient care and then graduating to out-patient status. Some programs, however, do away with the inpatient stage, they may begin in a half-way house setting or operate on an out-patient basis from the start.

Treatment services are usually provided by one of five types of facilities (a) a specialized unit in a larger institution such as a state mental hospital or prison, which is primarily devoted to treatment and rehabilitation, (b) a self-help community mostly utilizing confrontation therapy (for example, Synanon), (c) a private psychiatric or general hospital often admitting a patient under a psychiatric diagnosis, (d) a state mental hospital but not in a special drug unit or treatment program, and (e) community mental health center-addiction units.

At the present time it is impossible to determine how many treatment programs and facilities actually exist or how many are needed to meet the need.

3. Aftercare

Once the patient has withdrawn from the use of drugs and has begun to understand and deal with the emotional and behavioral problems associated with drug dependence, he needs a range of supportive services and assistance in finding his way back into the community.

He may need to return for additional therapeutic services during periods of stress, for family counseling because of problems in adjusting to a new life, for occupational guidance, and for social services relating to housing, legal assistance, etc. These aftercare services help facilitate the difficult process of re-entering society, without them the patient all too often is again overwhelmed and relapses into renewed dependence on drugs.

These services can be provided in basically three kinds of settings (1) a protected setting, such as the half-way house or sheltered workshop, (2) an outpatient facility either autonomous or associated with the treatment facility, and (3) out in the community--on the street, in the home, on the job, wherever the patient is--utilizing a "streetwork" staff. There seems to be a growing awareness that provision of aftercare services to persons emerging from intensive treatment programs is essential to successful rehabilitation. Drug dependence does not lend itself to easy and quick solutions, it requires a long-term effort.

All treatment modalities are designed to improve the effectiveness of a client in his everyday functioning. Through this improved functioning, the individual's potential for employment is enhanced. The emphasis and philosophy of these treatment modalities, however, differ greatly from the one extreme of total abstinence to allowing the addiction to continue under controlled conditions.

CURRENT TREATMENT MODALITIES

The three major kinds of current treatment modalities are (1) Methadone maintenance and antagonists, (2) Self-help communities mostly utilizing confrontation therapy, and (3) Multi-modality programs based on psychotherapeutic concepts.

Methadone Maintenance and Antagonists

Methadone maintenance is a drug substitution program in which the narcotic methadone is given to persons who are dependent on heroin.

The methadone treatment is the result of intensive research work conducted at Rockefeller University by Vincent P. Dole, M.D., a metabolic research scientist, and Marie Nyswander, M.D., a psychiatrist with long experience in drug addiction problems. In 1963 they discovered that an addict's drug hunger could be successfully blocked by large doses of a known drug called methadone, and that he remained impervious to the effects of heroin as long as he maintained his methadone level. In this study,⁴ they further discovered that, even if the methadone-maintained patient experimented with heroin, the drug had no effect on him at all. Thus, with his drug hunger removed and an effective narcotic blockade achieved through methadone, the patient became receptive to rehabilitation.

The study concludes that methadone is fully as addicting as heroin, taken orally, methadone provides no euphoric "high" and thus does not interfere with the user's day-to-day functioning, daily oral administration of high dosages (100 mg) effectively blocks the "narcotics hunger" in some heroin addicts, and it is legally prescribed as part of a public program and thus does not involve the user in the desperation and criminality so often associated with dependence on heroin.

Methadone has been criticized by some on the following bases it does not cure the medical condition, much more clinical experience is needed before we

can venture to make this a full-scale public program; it supports a drug addict in his addiction., it is dangerous to the individual and to society to have a whole class of persons totally dependent on the state for a substance which they cannot do without and it is admission that there is no traditional method of rehabilitating the heroin addict.

Jerome H. Jaffe, M. D., Director, Special Action Office for Drug Abuse Prevention, observes that

"The methadone maintenance approach is predicted on the proposition that any medication that permits a compulsive narcotics user to become a law-abiding productive member of society should be considered as a therapeutic technique. If the medication is a narcotic, it need not be eliminated from consideration since the goal of treatment is socially acceptable behavior, rather than abstinence per se--- Methadone maintenance has been criticized as the 'substitution of one habit for another' implying that all habits are equally deleterious. This implication is supported neither by common sense nor by observation." 5

Methadone maintenance is a useful approach to rehabilitating heroin addicts, but is no panacea.

In many communities there seems to be an increasing trend towards methadone maintenance. A recent article in The New York Times reported that many of New York's elected officials are turning away from psychotherapy as a way to treat heroin addicts and are relying instead on chemistry, (that is,,Methadone maintenance).

While methadone dominates chemotherapy now, some are promoting research projects to find alternative chemicals Cyclacozine and Naloxone are in a group called "antagonists." Like methadone, the antagonists block the effects of the opiates, unlike the methadone, they are non-addictive.

Self-Help Approaches

In the self-help approach, drug use is seen as the immature personality's escape route from reality. The object of the treatment, therefore, is to help the patient achieve sufficient emotional maturity so that he can face life on his own without depending on drugs.

Their techniques include (1) placing the drug user in a structured peer group setting of former drug users and (2) using the social pressure of their combined support or disapproval (aided by status and occupational rewards). Because former drug users themselves have only recently become converts to the straight life, there is an element of zeal which tends to reinforce their efforts.

Self-help approaches to drug treatment and rehabilitation may take a variety of forms. Some resemble Synanon in California, others are closer to Alcoholics Anonymous, still others are linked very closely to a religious experience and are associated with religious organizations.

1. Teen Challenge

An example of the religious approach, Teen Challenge of New York City requires that all new members undergo immediate detoxification without medication. At the Induction Center members participate in Chapel services, Bible classes, recreation, and group therapy. After a few weeks, they are then sent to more intensive training centers outside New York City.

2 Synanon

The Synanon Movement, one of the earliest self-help groups, was founded in 1958 by Charles E Dederich. Synanon today has grown to such an extent that it is considered one of the major agencies in the

area of drug addiction.

Synanon is a nonmedical program of residential group living which is operated exclusively by recovered addicts. Of the original 2,000 members, it is estimated that 100 to 200 have returned to the community and that the rest are working in Synanon business activities.

Applicants to Synanon are screened by interview. On admission, each applicant must undergo a process in which he recognizes in a frank and unwavering way the extent and seriousness of his problem. Once in the organization, the newcomer has to endure withdrawal in full view of other residents. Reports state that the physical symptoms are almost always mild, this is explained on the basis that withdrawal distress is as much a reaction to the emotional deprivation of drugs and the impersonality of a hospital or cell as it is a physical response. A resident usually becomes a lifelong member and works in new centers now being established.

3. Daytop Lodge and Village

There are a number of outgrowth programs from Synanon, one of the better known is Daytop Lodge and Village. It shares with Synanon the practice of group sessions where addicts are exposed to intensive testing of motives and attitudes in the hope that they will learn to face reality. Unlike Synanon, it accepts referrals by the court and other agencies and prepares its members for discharge after a period of approximately one to one and a half years. Daytop and other similar programs differ from Synanon in that they employ some professional staff to assist in the treatment program.

Some of the major criticism of the self-help approach are that the theory of personality maturation is far more complex than the self-help proponents realize, that confrontation sessions face the patient with only a very

limited form of "reality" and hence may not be adequate preparation for re-entry into society, that the very abrasiveness and harshness of criticism during a confrontation session may, for some patients, be destructive rather than therapeutic.

Nevertheless, the self-help theory approach has gained widespread interest and support. Many self-help facilities are receiving financial support, some on a fee-for-service basis, from Federal and State entities. It seems likely that at least some elements of the approach will become standard parts of the continuum of drug abuse rehabilitation.

Multi-Modality Programs Based on Psychotherapy

The third major treatment method may be described as a multi-modal treatment approach based on psychotherapeutic concepts. Until quite recently, most persons treated for drug dependence did not participate in either methadone maintenance or self-help programs. They usually entered programs which provided a range of more traditional services including medical detoxification, individual and group psychotherapy, and social and vocational counseling. These programs were located in different kinds of settings, but all had a common reliance on medical, mental health, social services professionals as therapists and directors of the rehabilitation program.

The emphasis on psychotherapeutic services was related to the assumption that drug dependence is a function of underlying psychological problems and that the way to treat dependence is to treat the underlying emotional problems.

To understand this mode of treatment, it must be noted that within the general helping services there have been significant changes in the traditional psychotherapeutic approaches. Two of the most important changes are the movement away from institutionalization to treatment in community-based centers, paraprofessionals and other people (for example, ex-addicts) in treatment programs. (For further clarification of this movement see Principles of Psychiatry by Gerald Caplan⁶). According to the Chicago Drug Rehabilitation Program, the ex-addict with training is the primary therapist

in their treatment program. Professionals serve primarily in administration, supervision, and research roles

Thus, while psychotherapeutic services may still form a backbone of the treatment process, they now tend to be offered in combination with numerous other kinds of services including methadone maintenance, as well as self-help confrontation groups with ex-addicts functioning as therapists ---hence, our use of the term "multi-modality." These programs, while quite new, do have tremendous possibilities, especially when well coordinated.

In summary, the development of all three types of programs should be encouraged and supported as part of a comprehensive approach because different patients respond to different kinds of treatment. Only by continued experimentation will it be possible to develop improved and more effective rehabilitation methods.

Training, Placement, and Follow-up Services

The medical and psychotherapeutic services afforded to the client occur typically within the treatment modalities described. Training, placement, and follow-up--the traditional contributions of the State VR Agency--exist concurrent with, or subsequent to, the medical and psychotherapeutic services. A description of these services available to a drug abuse population follows

TRAINING

1. Pre-vocational Training

The importance of a pre-vocational training program with its evaluation and adjustment components is suggested by Richman⁷ in reporting the experience of the New York State VR Agency in serving drug addicts. He states that a major factor for lack of success is failing to recognize that the addict "after detoxification or drug substitution continues to be the same vocationally limited individual. even though he may appear able to work and in need of work"⁸ This "fragile state of equilibrium," Richman continues, makes adjustment services and the use of a rehabilitation facility vital in a total program of services.

As previously indicated, the psycho-social elements in the drug abuser's situation often preclude an accurate assessment of his vocational potential by means of paper-and-pencil tests. Too, because many drug abusers are members of disadvantaged communities, the validity of standardized testing in appraising their vocational potential is open to question. In discussing cultural bias of testing, Cody⁹ notes that "many individuals are discriminated against because they lack the experiences that would enable them to do well in a testing situation" and consequently "would be less likely to be selected to get further education or a better job." It would appear, then, that for this population it is highly important to employ a work evaluation center which offers a work-sample type of evaluation and, in addition, evaluation of other significant work-related behavior work habits, interpersonal relationships, reaction to supervision, and the ability to structure one's work.

The work-adjustment training process is familiar and well utilized within State VR Agencies and, therefore, no extended description is necessary. As for applicability to the psycho-social and vocational needs of the drug abuser, the fundamental nature of the program as stated by Leshner¹⁰ is of interest

"The client is offered a progression of success experiences, achieved with some strain at his readiness level. It is developmental, learning by doing activity, operating on the broad principle of building confidence, general work competency and particular coping behaviors. The process is often coupled with an array of supportive services that pertain to special health, family casework, education, and counseling services."

The outcomes, according to Leshner, are orientation to selection of training or of occupations, and the initial capacity to enter and maintain these endeavors.

2. Vocational Training

The deterioration of employment skills during the disability of the older drug abuser and the failure to acquire vocational skills on the part of the younger drug abuser point to the importance of vocational training and of its precursor, pre-vocational training. The positive relationship of vocational skills to placeability is axiomatic in vocational rehabilitation, and development of such skills should substantially increase placement opportunities for this disability population which generally has such marginal access to employment. Pressure by the client for immediate placement, a not uncommon factor, in apparent disregard of a substantial vocational future, cannot be ignored or resolved easily. The counselor should explore with the client his perceptions and motivations regarding the urgency for immediate employment at the possible expense of future vocational substance, and he should identify as clearly as possible the reality factors involved.

The traditional constituents of vocational guidance in occupational choice and related vocational preparation should be maintained at this stage. Occupational choice and related training deriving from (1) appraisal of mental ability, aptitudes, personality, i.e., attitudes, values and needs, (2) physical capacities commensurate with the demands of the occupation selected, and the potential for satisfaction of financial and personality needs within the occupation.

The psycho-social area of functioning, or dysfunctioning as related to the social norm, is quite likely a predominant problem for the drug abuser. Central is his self-concept of inadequacy, which frustrates his acceptance of the worker's role. It would seem, therefore, that for many clients a therapeutic approach aimed at helping the individual develop coping abilities should precede and later accompany the training program. Properly selected, however, the training situation of itself can strengthen the client by providing him with success experiences, such as the mastery of job skills or curricula.

The counselor should be particularly careful to select and recommend those training facilities which offer full vocational preparation for existing or projected job opportunities. In addition, the participation of the client should be maximized as his investment and contractual obligation. For example, if several situations offer comparable training, the client should be expected to visit these and make his own selection.

In considering training facilities the counselor should be alert to the "feeling-tone" of the facility. To be considered are the "climate" factors that affect the client's course of training, such as receptivity to the handicap, the apparent intent to assist with placement, and the relationship qualities of the training staff. The counselor's intuitive judgment of these factors should be respected.

On-the-job training deserves some special emphasis as perhaps particularly responsive to the client's need and/or demand for immediate employment. Because it offers an opportunity in concurrent skill development and wage earning--a prevalent factor in the immediate employment demand--on-the-job training appeals to many clients and is an appropriate step for them. Additionally, the possibility of structuring this type of work-learning experience to the needs of the individual client increases the potential for success. The usual implied agreement by the trainer-employer to hire the trainee upon successful completion of the traineeship further enhances the possibility of a successful outcome.

Placement

Although data concerning the attitudes of employers toward hiring the drug abuser are currently not available, it must be presumed that a substantial negativism exists. Employers share the prevailing perception of the drug abuser as anti-social, unstable, and irresponsible, and fear is voiced that he is a possible source of contagion in the place of employment. Nor can it be denied that

this appraisal is based on the actual experience of some employers with drug abusers, the nature of the drug abuser's illness in its active process precludes responsible and stable work behavior. Additionally, treatment success has progressed slowly and is not widely publicized, so that a momentum of employer confidence in the rehabilitation potential of this disability group is yet to be generated.

Given a stereotyping which tends to stigmatize the drug abuse population generally, the critical issue in placement is to encourage employer receptivity. In the approach to employers, the factor of differentiation must be stressed. The distinguishing quality of the State VR client referred for specific employment is a demonstrated potential of at least minimal acceptable capacity for the job sought, a potential arising from client's progress within foregoing services which can be documented to the employer. This is not an assurance of success to the employer, rather, a probability of success is being offered.

To maximize this opportunity for success for both client and employer, it is essential that the client's capacities for the prospective job situation be fully appraised. Counselor and client, together, must evaluate job readiness.

Several schema outlining the attributes of physical, psychological, occupational, and placement readiness have been developed to assist the counselor. An example of this evaluative instrument developed by Viccelli¹¹ is given in the Appendix.

Because of the considerable difficulty to be expected in effecting placement, it is probably helpful to enlist the support of members of the community "power structure." Trellis,¹² in describing a pilot treatment program of narcotic addiction, states that because of the intercession of a prominent local employer on behalf of program clients, finding employment for them was not a major problem. This strategy is also illustrated in the work of Bill Sands, because he aroused the interest of influential community members in penal offenders, a

hard-core, difficult-to-place group was released and employed.

It should be reaffirmed that counselors have, as placement prospects, screened individuals who present the employer with perhaps a lesser risk than "off-the-street" hiring. Whenever an employer has reservations about hiring because of the possible instability of the client, the counselor should state forthrightly his commitment to continuing service to the client in areas necessary to maintain employment. The counselor's continuing interest and the availability of various resources of the Agency should also be stressed.

Generally, the characteristics and functions of productive placement programs for the disabled are applicable to the drug abuser. Extended descriptions of these programs appear in several sources. For the purpose of an overview, the components of such programs are summarized below

1. Pre-contact Planning

The development of working relationships with community agencies to get information about prospective employers and secure influential support for employer contact.

2. Approach

The "sales" presentation to the employer emphasizing the advantage of hiring the handicapped person. Integral here is promoting interest and positive action.

3. Plant Visit

On-site analysis of the job to determine its suitability for the client.

4. Job-Entry Assistance

Counselor service in preparing the supervisor and co-workers for introduction of the

client to the job situation, concurrent preparation of the client for the specific work setting

Follow-up

It must be emphasized that the individual newly placed in employment enters a new environment with its particular demands and set of relationships. Despite the individual's preparatory training, this new environment holds some unfamiliar aspects and possibly disturbing elements. Consequently, the individual may require considerable clarification and support in order to adjust to the situation. The counselor's ready availability to the client may be a prime factor in effecting the adjustment.

Full recognition must be taken, too, of the possibility that situations external to the job setting may disrupt the client's work functioning and introduce the need for the counselor's intervention. Stability of the client's family situation, for example, may be presumed to have a positive effect on employment stability. Recent evidence specific to the drug abuser appears to support this observation. A report on The NYC District Office Addiction Program¹³ of the New York State Office of Vocational Rehabilitation for a one-year period (1968-9) states, "Marital status can be considered as significantly related to rehabilitated outcome, and being married or having a spouse appears to have prognosticated 'success' in a rehabilitation program." Thus, the input of ameliorative services, through the efforts of the counselor to job external problem areas as, for example, procurement of case work services for critical marital problems, may be of major importance.

The question of fostering dependency sometimes arises in connection with this type of continuing services. Sinick's¹⁴ reply is pertinent

"While weaning a client away from dependency is a common responsibility, the client's ultimate adjustment is a

greater responsibility. If follow-up would serve this end, it should be conducted with weaning occurring concurrently. Follow-up activities would be planned to taper off appropriately."

This statement implies no fixed cut-off date for follow-up services but rather it suggests concluding this service when the counselor is satisfied that the individual has achieved a reasonable level of social and vocational functioning.

The "counselor availability" factor--of prime importance in this stage of rehabilitation--requires that the counselor keep well apprised of the client's situation and that he plan for as frequent contact and service intervention as the situation indicates. No particular duration or frequency of contact is suggested, the client's individual circumstances and the counselor's judgment should determine these factors. Experience indicates, however, the need for greater frequency of contact during the first several months following placement, because this period is typically more stressful, thereafter, contact may be less frequent.

Job retention, although primarily and properly a focus on service to individuals, should be recognized as having also a collateral value. When a drug abuse client is satisfactorily placed, he contributes not only to a positive employer experience, but hopefully promotes receptivity to the employment of other rehabilitated clients within this disability category.

REFERENCES

1. Frederick Wiener, "Planning Aftercare Community Services," Rehabilitating the Narcotic Addict, Washington G.P.O., 1967.
2. Ibid.
3. Meyer H. Diskind, "The Role of the Parole Officer on the Use of the Authoritative Case Work Approach," Rehabilitating the Narcotic Addict, Washington G.P.O., 1967.
4. Vincent P. Dole, M. E. Nyswander, and A. Warner, "Successful Treatment of 750 Criminal Addicts," Chicago The Journal of the American Medical Association, 1968. Vol. 206, pp 2703-2711.
5. Jerome H. Jaffe, "Statement on August 8, 1969, before the Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare," as quoted in Drug Use and Treatment Programs for Drug Dependent Persons in New England, Boston The New England Economic Research Foundation, 1970, pp. 35-36
6. Gerald Caplan, Principles of Psychiatry, New York Basic Books, Inc., 1964, Chapter 7.
7. Sol Richman, "The Addict as a Rehabilitation Client," Rehabilitation Record, 1966.
8. Ibid.
9. John J. Cody, "Appraisal of Disadvantaged Youth," Counseling the Disadvantaged Youth, (W. E. Amos, ed.), New Jersey Prentice Hall, 1968
10. Saul S. Leshner, "The Relationship of Work Evaluation to Work Adjustment Training," Journal of Rehabilitation, 1970.
11. Louis Viececi, Placement of the Blind in Competitive Employment, Unpublished paper.
12. Emil S. Trellis, M.D , "A Pilot Project in the Pittsburgh Area," Rehabilitating the Narcotic Addict, Washington G.P.O., 1967.
13. Statistical Report New York District Office Drug Addiction Program, New York State Office of Vocational Rehabilitation.
14. Daniel Sinick, "Training, Job Placement, Follow-Ups," The Vocational Rehabilitation of the Disabled, (D. Malikin and H. Rusalem, ed.), New York University Press, 1969.

APPENDIX A

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APPENDIX B

CHARGE TO PRIME STUDY GROUP I

Title Rehabilitation of the Drug Abuser

Objective The purpose of this study group is to study concepts, principles and techniques in the rehabilitation of the drug abuser with the goal of developing suggested operating procedures for the rehabilitation agency and its counseling staff.

The following charges were outlined by the Planning Committee for the 1971 Institute on Rehabilitation Services

- A. To ascertain the nature and extent of the problems of drug abuse and the implications of these problems for vocational rehabilitation by the State VR Agency. In this connection, the subcommittee suggests that the prime study group might consider the following study elements
 - 1. Surveying the literature.
 - 2. Compiling appropriate demographic data.
 - 3. Defining terminology in current usage
 - 4. Defining the specific role of the State VR Agency in the community of treatment resources for the drug abuser.
 - 5. Examining eligibility criteria in relation to client acceptance.
 - 6. Examining the social context of drug abuse.
- B. To identify the population that should be served by the State VR Agency and the supporting reasons for client acceptance as directed by eligibility criteria. Here the subcommittee suggests examination of the medical, legal, social and vocational meanings of drug abuse as assisting in defining the population to be served.
- C. To describe a model of State VR Agency service to drug abuse clients encompassing organizational structure, procedures, staff skills, and facilities necessary for service. Possible areas of suggested study include
 - 1. Agency climate of acceptance Administrative and staff attitudes
 - 2. Financing special programming.
 - 3. Case Finding.
 - 4. Staff knowledges.
 - a. Psychodynamics of drug abuse.
 - b. Medical information.
 - c. Special counseling skills.
 - d. Treatment
 - e. Law enforcement and legal considerations.
 - 5. Needed service resources.
 - 6. Services to families.
 - 7. Follow-up services.
- D. To develop a document covering the subject matter of the above charges and to select appropriate collateral readings to accompany this document. To provide also within the document a glossary of technical terms and jargon current among drug abusers.

APPENDIX C

Interview with a Former Drug Addict
Recorded February 5, 1971.

The person interviewed in this tape transcript had been a drug addict for twelve years. For the past two years he has served as a counselor to drug addicts in a hospital. The reasons for including the interview in this document were discussed with him fully and agreed upon--both verbally and in writing. We will refer to the person as Paul. The comments made by Paul are his, and do not necessarily reflect the thinking of Prime Study Group I.

Interviewer (I) Paul, would you tell us about yourself and your background?

Paul (P) I'm now thirty-five years old. My first experience with heroin was at the age of fourteen in New York City. But I didn't become addicted at the time, it was just a one-or-two-time thing. Later, in 1958, I became addicted to a cough syrup which I took for about two years. This cough syrup is no longer being produced, it was taken off the market. It was merely a matter of transition from this opiate, which was codeine, to heroin. By 1960, I was actively engaged in the use of heroin.

I Paul, at what point in your life did you realize that this had become such a problem that you needed help and how did you go about seeking this help?

P Well, it was almost immediately after I became addicted to the drug. I knew my first experience with withdrawal. I was in New Jersey, on my way to New York on the New Jersey Turnpike. My car broke down and I had some other difficulty with the police on the turnpike and I was incarcerated for three days. This was approximately 1960. Within a three-day period, I went through withdrawal and it was a very miserable experience, very frightening. At the time I didn't know where to get help. There wasn't too much help available for addicts in those days, even in New York. So

over the next ten years it was a matter of trying to support this habit by stealing and various other nefarious activities. I was arrested approximately 17 times in four states. It got to the point where it became physically impossible for me to go on. My veins retreated to the bone in self-defense almost. By this time, treatment programs were springing up all over the country. With the help of Methadone Maintenance I was able to kind of break this thread.

I Are you currently taking methadone?

P Yes, I am.

I Paul, what did this habit cost you?

P Well, I think the highest was around \$80 a day in New York City.

I Were you working at all during this time?

P No. I found I couldn't hold a job for any length of time. If I had the drug, it was impossible to work. The supply wasn't a continuous one and, of course, the cost was prohibitive. I couldn't support my habit with a normal job.

I This is important then to the rehabilitation counselor in his approach to a drug user, abuser, or addict, isn't it?

P Yes, it is indeed.

I What would you advise the rehabilitation counselor to do in this respect? He may consider himself rather inadequate to deal with this. Would you advise that he team up with someone, a person such as yourself, so as to facilitate counseling?

P Possibly, in the beginning. But I think that in working with addicts a counselor learns on a trial-and-error basis whether he can function with the addict. He learns the addict's psycho-methodology if he works with him long enough.

I Could he make some mistakes, though, in such a procedure? Let's assume that the addict, to support an \$80-a-day habit, will be manipulating. There doesn't seem to be much that the rehabilitation counselor can offer him. You know, the counselor may say, "I can get you an \$85 a week job." This is not very intriguing, is it?

- P Well, I don't believe you can function in that way with an active addict. I believe that an addict, first of all, in order to engage in gainful employment or to do anything constructive, must be in treatment. He has to be motivated. If he's not, then the words are just little bits of air.
- I Paul, during the many times that you were incarcerated, did you get any kind of treatment at all within the confines of the prison system?
- P No. I found that the jails in New York and Baltimore and New Jersey shied away from treatment of addicts.
- I From time to time some of our prison officials have included in their budgets an item for treatment and drug therapy for the addict. Do you feel this ought to be part of the budget in the correctional system?
- P Yes, but it should be more than a mechanical dispensing of methadone. I think the addict needs a certain degree of therapy and supportive help also. Methadone Maintenance is really not necessary in jail on a long-term basis because if the jail is secure there is no heroin anyway, and they don't have a heroin problem. Maybe to bring about withdrawal, yes. But as far as maintenance is concerned, I don't see the need for it really.
- I Paul, have you found any problem "functioning normally" while using methadone?
- P Yes. Methadone does have certain disadvantages. The physical ones, of course, are constipation (but this does not last), certain reduction in the sex drive (which can be quite a problem). Now, of course, methadone is a habit-forming drug. It does not create or produce the euphoria that the opiates do, but the methadone taker is dependent on it and he can't, you know, journey too far away from the clinical sources of supply. This is a problem in the event that he wants to travel, or go on a vacation, or engage in some sort of activities that involve going away.
- I As far as functioning on the job, it doesn't hinder you in any way?

- P No As a matter of fact, for the first time in many years, after I began taking methadone, I was able to function normally on the job. Methadone doesn't create euphoria and so a person can function. His equilibrium is maintained and his thought processes are just about normal, so, he can function.
- I Paul, in many cases we hear the addict state that he becomes an addict due to his background and he usually tries to relate this to some psychogenic overlay. How much of this do you feel is true?
- P Over the years I have met addicts from all walks of life, all economic strata, all types of people, and it's my belief that in order for a person to become addicted to a drug, in order for a person to use heroin, three things must exist there has to be a degree of emotional instability, there has to be an available supply, and, of course, there has to be a method of bringing the two together. Without any one of these the addict wouldn't exist.
- I Many of our counselors feel quite uneasy working with an addict. You've been a counselor Would you tell us some things you think a counselor ought to do or ought to know when dealing with the addicts? Some guidelines?
- P Well, first, of course, I think the counselor must attempt to understand the addict's problems He must realize that this is a man or woman who, except for being addicted, probably would have been just like himself. The counselor has to be sincere, he has to make the addict feel that he is really attempting to help and it's not merely a job You've got to remember that the average addict comes in contact with many people--social workers, judges, probation officers--in the course of his addiction, and he is able to sense sincerity. He is able to sense a person's interest in him and he is pretty sharp. Never underestimate an addict, he's a pretty sharp guy. He can manipulate, that's what he has been doing all day for probably years in order to support his habit. And he is very perceptive, as you know
- I Manipulation and conning, these are hazards that a counselor feels. He, too, knows that he is being manipulated, and he is always wondering "When do I really tell this guy that he

is conning me? When do I tell him that I'm being manipulated, that I'm getting a little sick of it, and let's level with each other?"

P I wouldn't be too afraid of the word "manipulation." There is positive manipulation also. Everybody manipulates. The degree to which you succeed in life is based on the ability to manipulate. It's when this ability becomes negative that you have to watch out. So, it might possibly be to the counselor's advantage that this guy is manipulative, but in a positive sense.

I We hear today that only ex-addicts can make good counselors with the drug user now. How do you feel about this? Can a professional really relate? Does he have to know the jargon? Does he have to have highest experience with drugs himself to really be helpful to the addict?

P I don't believe so. I don't believe a doctor has to have a baby in order to be a baby doctor. It might help in understanding the psychomethodology of the addict, but it's not necessary to do the job. The addict, you know, is pretty sensitive, and he can feel things. If the counselor makes too great an effort to get down to his level, he can perceive this and he knows it's a game, it's a lie, it's not the way this man really is. And if this man will do this, then what won't he do, you know? The counselor should be for real. He should be himself and attempt to develop a kind of relationship which contributes to what he is trying to do for the addict.

I In many areas counselors are assigned to addicts only. Sometimes those who make these assignments are in a little bit of a quandary. Should an addict work with addicts only? Would he be better off working with people across the board whatever the disability and have addicts as only part of his case load? How do you feel about this?

P Of course, just because a person is an addict does not qualify him to work with people. There are all types of addicts. You have addicts who can work with people, and you have addicts who can't. But an addict with any degree of intelligence usually has lived close to the margin. Let's say he knows people, he has lived in the street, he has been involved in

that sub-culture, and he might be a little more perceptive to people's problems if he knows the resources that are necessary to help a person. He probably would make a very good counselor.

I I was thinking of our general counselor who handles addicts as part of his case load as compared to having a total case load of addicts.

P Oh, I see. I don't know, I couldn't answer that.

I I suspect that it may relate to theories of counseling that if you can counsel with one type of disability, then possibly you are going to be effective with all types. But, I suspect all types of vocational rehabilitation counselors nationally do have some doubts about this new population of drug addicts. Perhaps we need to go to school, or perhaps we need to join hands with counselors like you, who are now involved

In the 18 months that you worked in the hospital facility as a counselor, what kind of vocational needs have come to your attention in the population you worked with?

P Usually when we got the addict, he was in the last stages of addiction. What I mean by that is if the addict was referred to us by the courts, or the parents brought him in, or if he came in for any other reason that his own free will, we found that we didn't have too much success. Regardless of how good the quality of the counseling was, he wasn't ready. You find that you have much more success with the motivated addict. This is the guy who is tired of hustling, he is tired of using drugs, he is tired of the trials and tribulations of obtaining \$80 or \$90 a day. He's tired of going to jail, he's tired of the whole bit. He's tired, he's sick and tired, he's tired of being sick and tired. And with this kind of guy you'll find that he's uprooted. He doesn't have a job, he might not have any stable living arrangements, his family and friends have forsaken him, and he's just in bad shape. Most of the counselor's work will be in referring this man to specialized agencies, for example, to the Department of Welfare, the Department of Social Services, in order to provide for his subsistence and shelter needs until he's able to find gainful employ-

ment, and to help him find a place to stay, if possible out of the sub-cultural climate that he is used to. These are the types of problems that you have. If the fellow has been a drug addict long enough and is old enough, you'll find in a number of cases that he has broken down physically. He might have abscesses, he might be damaged internally, his liver or circulatory system and his heart might be damaged, and of course, if this is the case, you have to straighten this out before you can even begin to hope to straighten him out

I How about training needs for new skills and new jobs? How much of this is a need?

P It all depends. For some reason, people believe that addicts are unskilled. As I said, there are all types of addicts. It all depends when the person became addicted. Now I have found that if a guy began using drugs at 16 and he stopped at 30, he is still 16 in a lot of ways. He doesn't know what responsibility is. He has functioned in such a way that he hasn't been an asset to himself and society. Even though he's 30, he's still 16. In those cases you might find that the guy can't do anything. But, of course, you have addicts who become addicted at 25 and who have worked for 10 years. There's no stereotype for addicts, it all depends on the individual. You can't answer that question generally.

I Paul, when a rehabilitation counselor begins with an addict and tries to develop a service program for him, there is a great deal in the literature about the drop-out rate, or his not using service, not coming back. What are some of your views as to how the counselor can get into this area? What are some of the things the addict needs to keep him in the rehabilitation program?

P You've got to remember that this is a man. He's been an addict for ten to eleven years and he hasn't worked. He's infected by the street. He is not used to routine. He has been spending large amounts of money on drugs daily, usually what amounts to a week's salary for most of us. He doesn't really appreciate what money is. Every dime he's got is going through his arm instead of

on his back. And if he's not on a treatment program and if he's not motivated, you're not going to have too much success with anything you do with this guy. Usually the motivated addicts and the ones who respond to your efforts are people who are on treatment programs, they are not as susceptible to recidivism. You will probably find that with good counseling you can succeed in whatever you want to do with this guy, if it's not above his ability to accomplish.

I Are his needs more specialized, and in what way as compared to other rehabilitation clients? What are the particular needs of addicts a counselor must deal with?

P The biggest problem you'll have with the addict is the possibility of his returning to drugs. Now, there is no one answer as to why he'll do this, but I think this is one of the biggest problems you will have. Try to head him off when he seems to be backsliding. The chances are that you can be successful with him.

I What does he need to head him off?

P It all depends on his circumstances.

I What should a counselor's reaction be to backsliding? Should the attitude be one of "I-told-you-so" and total rejection of services at that point? How do you see this?

P Well, with the rate of recidivism as high as it is, I think that you should keep in mind that the possibility exists. As a matter of fact, it is probable. If he doesn't backslide and use drugs again, then you know that something is being done right (even though you might not know what it is) and just thank God this is being done.

I If the intervals of slipping and the return to drugs keep getting further apart and less frequent, you consider this real progress?

P Yes, indeed.

I: From time to time you have mentioned the levels of addiction, what do you mean by levels of addiction?

P: Maybe I can answer the question this way. There is usually a process a person goes through when becoming a heroin addict. He doesn't begin using heroin daily. He might begin on Friday nights and Saturdays and this might go on for as long as a month or longer. It depends on the person, the supply, etc. Then he might begin using it on Saturday, Sunday, and Wednesday. Then he might take it Saturday, Sunday, Wednesday, and Friday. And all of a sudden he is using it seven days a week. Now at no time, I think, does a person believe that he will become addicted to heroin. Everybody believes, "I can use it once and then to heck with it." But it is a very pleasurable sensation, it is very magnetic and you usually rationalize yourself into believing that one more time won't hurt. And you use it long enough or to the extent where your metabolism becomes dependent upon this opiate.

At that stage, of course, you're addicted. I've found that the people who have been addicted to heroin the shortest period of time are really the hard-core addicts. These are the guys who haven't been made miserable by the acquisition of heroin. They haven't experienced the trials and tribulations for a long enough period of time so that they are really motivated to stop. It seems that it is easier to work with the addicts who have been addicted for ten, eleven, or more years. The younger boys, the younger people who are using heroin now and are addicted, seem to be the hardest ones to work with. They usually come to us through the courts, because they've been arrested, or their parents bring them in, or anything but coming in by themselves. And I think that the way a person seeks help is an indication of how he will benefit by it.

I: Earlier, we talked about the return to drugs while the counselor is working with the addict. At what point do you think the counselor should do some disciplining of the addict, or do you think this in order at all?

P: I think it should be tried, but, as I say, addicts don't usually respond to words. They respond to actions.

It's my belief that when a person goes back to the use of drugs, he's already gone too far so that words can't help him. If you can put that type of pressure on him before he actually begins using drugs (now, I don't really mean pressure, you know), but if you can make him understand that he is progressing, that he is doing well, why give it all up for something that is not tangible, like heroin use, when he is doing as well as he is? I think, if he is motivated at all, you can just about head off the recidivism.

I The counselor should be willing to accept some slips then?

P Yes, of course He should expect them.

I Paul, do you think a single counselor should deal with the addict, or would a group or team be better?

P That again also depends upon the personality of the addict. If you listen to what an addict has to say, rather than concentrate on what you have to say to him, you'll find a lot of clues as to the treatment, the best response to use, or what's necessary to get him to do what. I think it's a decision based on the individual.

I Paul, I doubt if today there is a school in any of the states that doesn't feel that there may be an addiction problem of some kind within its system. Would you tell us a little bit about this since you have been in the field?

P It seems that during certain years of a person's life, mainly as young as ten now and as old as twenty-two, he seems to be more susceptible to this curiosity thing that makes a person involve himself with drugs. In all the years that I have been involved with drugs, I really know no one over thirty-five who, as a result of curiosity, began using drugs for the first time. And I think that this is why we are having this hard drug problem in schools. They are just at that age to have the attitude "What's all this talk about drugs? Let me see what the heck it is." And, as I say, drugs do produce a pleasurable sensation and do solve some problems that emotionally disturbed people have. Then they rationalize on having

an excuse to use them over and over again, and they become physically dependent. It isn't a matter of curiosity anymore, it's a matter of having to do it. And they've started on the chase.

I Do you think that some of our high school drop-out rate has been the result of an attempt to subsidize the drug? They drop out and work to get money to stay on the drug?

P Sure. When you begin using heroin or any habit-forming drug, your moral and ethical values are affected. Your conscience almost disappears. You have no initiative and all of your effort is channeled into obtaining money to satisfy this need. I don't think you can go to school or work and be an addict, too, for any length of time.

I So far we have talked mainly about heroin use and a treatment process using methadone. Would you comment about the use of amphetamines and barbiturates which seem to be a problem especially among the school age kids where curiosity and experimentation occur?

P Even though I have never been involved in the use of amphetamines or barbiturates, I think that amphetamines and barbiturates are so prevalent among young people because of the source of supply, in other words, it is so easy to get. Their parents might be a possible source, and of course, I understand that many times the drug being used is produced actually in this country, and there is a lot of it around. Barbiturates are not like heroin in that they are not considered a neutral, they are highly habit-forming. As a matter of fact, I understand that the results of barbiturate use are much worse than the results of heroin use.

I We hear that speed kills and so forth, and we've talked about the team approach or whether a counselor really deals on a one-to-one basis with the addict. I'm wondering when we have a problem that is extremely dangerous and needs medical attention, when we're dealing with amphetamines and barbiturates, whether we don't really have to have a medical person involved.

P Yes, I would say you would have to have a medical person involved. The prime difference, or one of the more important differences, between the use of barbiturates and heroin, is that if withdrawal occurs in barbiturate use, barbiturates will not bring a person out, whereas heroin will, or methadone will. Epileptic seizures occur in barbiturate use, and there is the possibility of brain damage.

I This is true of hallucinogens, too, like LSD and that sort of thing. Do you have any experience with those?

P No, I don't.

I Paul, in terms of the peer group and hanging around with the "old gang," what's your attitudes about those?

P I have never known a heroin addict who uses drugs for the first time to be by himself, to go out as the result of curiosity and purchase heroin and the paraphernalia to use it, and to use it by himself. He is usually with someone else, a peer. I've read about peer groups being used to bring people out of heroin use--peers, of course, who don't involve themselves in the use of heroin. But I know that if a person becomes addicted to drugs and stops, the chances are that if he continues to associate with the same people, the peers who use drugs, he will almost always revert back to the use of drugs.

I So any counseling with the addict should be toward establishing a new set of friends and perhaps a new environment?

P The funny thing about that is I don't think a counselor can be very effective in helping a person establish a new set of friends. A person has to want someone as a friend. If he is motivated, he understands what is necessary to remain drug free once he has become an addict. This will be a normal thing with him. He'll see the need to establish new friends. He'll be tired of the whole life, the whole bag, and he'll come around himself. So, I don't think the counselor can be very effective in that respect. It's a personal sort of thing.

- I Do we have any statistics concerning the educational levels, the average levels, of the addicts you are working with? Are they school dropouts primarily?
- P Now, you can do surveys to determine the education level of addicts, but whether you can say that all addicts are addicts because they are school dropouts--well, do you understand what I am trying to say? It doesn't necessarily connect. There seems to be no correlation between the level a person attains educationally and the probability of him using drugs. But, people who use drugs and are in school will probably drop out.
- I From your experience with addicts seeking service or treatment, in the main what about their work records? What about their past educational experience? How good a work record? How high an educational background?
- P They seem to have poor work records and poor educational backgrounds.
- I From time to time we get addicts who ask to be relocated. They express fear of physical harm from the old gang because they have turned over a new leaf, so to speak. How realistic is this? Does the old gang resent a person going for treatment?
- P In the black community, in the ghetto, the attitude now is that it's a drag to use heroin. A person in the old gang who stops using heroin is given encouragement because his friends would like to do the same thing, but can't. I have found, however, that the attitudes seem to be different in suburban neighborhoods and the county in regard to white drug use. It seems to be the thing to do. Drugs have existed in the ghetto for a number of years, and it is not a new thing at all there. As far as I'm concerned, it has been just in the past five or six years that it has become a problem to this extent in the counties and it's a possibility that they have to go the route before they get disgusted with it, too. I don't know.
- I Paul, in terms of a public relations program to really get across the story about drugs, do you have any

suggestions?

P In talking to young people who are using drugs, it seems that a lot of their curiosity was a result of all of the publicity given to drugs--the bad publicity and all. The publicized deaths of well-known people, due to drugs, don't seem to make any difference. People have a tendency to believe that it won't happen to them. "These are just three or four individuals in a thousand who overdid it, it won't happen to me." I believe that curiosity is stronger than fear.

I You know, we say that the good guys wear white hats, this type of thing, and I think Madison Avenue probably has a great influence on what we buy and how we behave. From counseling standpoints I don't think that we could say that anybody using drugs is bad. But how do we go about saying this? Do we say, "it's good," "you're diseased," "you have a problem"? What approach do we use?

P This is a hard question to answer. It's just the way it is. I've said often that man has come very far in the last seventy years. He's got the automobile, airplane, television, telephone, atomic energy, he's on the moon today. And it seems we just haven't been able to keep up socially without kicking ourselves in the pants. It's created pressures and problems and anxieties for some people, and drugs seem to be the easiest way to alleviate these anxieties. And it's just being done more and more.

I Paul, one of the questions that the counselor is faced with today is does marijuana lead to the use of harder drugs. As a counselor with addicts for eighteen months, what are your feelings on this?

P I don't believe it does--not physically so. But I will say this. People who will use marijuana are more likely to use heroin. People who depend on this sort of sensation are more likely to use marijuana than use heroin.

I In the slipping and return of the addict, do they

sometimes substitute alcohol for the drug?

P No. Alcohol and heroin don't mix too well. I've had a number of friends die from what was considered an overdose of heroin, when, in reality, that was not the case. Heroin is a depressant and slows up metabolism. Normally, your liver is able to assimilate an ounce of alcohol every 75 minutes. When you drink alcohol and you're under the influence of heroin, more alcohol in the pure form gets in the blood stream. It's the alcohol that kills you, not the heroin. Heroin and alcohol just don't go hand in hand.

I In your capacity both as an addict and a counselor in the field, I'm sure you have known some pushers. Do pushers sell both heroin and some marijuana, or are they two separate fields?

P Well, they are two separate fields. Marijuana pushers consider selling marijuana a little safer. The customers they have are not as frantic, they don't have to go out and steal to support their habit. So, the chances of the customers getting arrested and informing on the pusher are not so great. The pushers will not make as much money, but usually they are afraid of heroin. They don't even use it. The heroin pushers don't bother with marijuana because it's too slow. What's happening now, however, is that as a result of the drug abuse programs in certain cities, the number of heroin pushers is decreasing and the number of cocaine pushers is increasing. The reason for that is that methadone does not block out the effects of cocaine use, the sensation involving cocaine use. And there is a lot of cocaine being used now, whereas at one time cocaine was unknown in many of these cities.

I One of the other objectives of the vocational rehabilitation counselor is placement. I've heard counselors say that they hadn't had much success sending the addict back into the field, such as drafting, engineering, and so on, and that most of their successful placements have been where the addiction has been kept right in focus, that is, in jobs directly related to drug addiction. How do you feel about this?

- P You'll find that when you're placing addicts in jobs, unless it's a job that they really want to do, something that will hold their interests, something that is creative as far as they're concerned, you might not have too much success. Remember that the addict has been involved in drug use which was to him very time-consuming, very enjoyable for a while, and his whole day was involved with doing this enjoyable thing. For him to work now and do something less enjoyable is a hard thing to do. I don't know if I put that right, but I think I got the thought over. He has to be doing something that to him involves more interest than heroin use.
- I You have been a counselor for the addict now for a number of years. How many other jobs did you try in the meantime and how many failures did you have? Would you have any idea?
- P Oh, yes. I didn't get a full-time job until after I graduated from college in 1958. Between then and 18 months ago, I had no permanent job because of my drugs.
- I How did you manage to get through college and sponsor your habit at the same time?
- P Well, that's another story. I didn't have a habit when I went to college. As I said, my first contact with drugs was when I was a thirteen-year-old. It was something new in those days, and I remember using heroin possibly for the same reason a kid smokes his first cigarette. There were no addicts around, nobody knew what this stuff was. I remember the first time I used it, it made me pretty sick. But I grew up with a very curious bunch of fellas (when I say curious, I mean we were very adventurous), and we involved ourselves in just about all kinds of things. We were juvenile delinquents. At the age of sixteen I committed a robbery, a felony, and I went to the reformatory for five years. I graduated from high school in the reformatory. I was released in thirteen months so I could attend college. I wasn't matriculated, however, and I was allowed to transfer to another college. As

a fully matriculated student a year after I came off parole, I graduated from college. Soon after, I got involved in drugs.

- I. Who sponsored your college training?
- P. My parents. In those days college education wasn't too expensive. I think it cost something like \$140 a semester. It was cheaper than that for state students. It kind of shielded me for four years. My parole officer required a B average of me, and in order to stay in college I gave it to him.
- I. Paul, in terms of job placement for an addict-client, what kinds of special problems should the counselor be on the look out for? What kinds of continuing services, if any, might the addict need?
- P. Counselors should remember that the businessman is not a sociologist. His primary concern is profit, and so when an addict or an ex-addict is considered for employment, the counselor should make sure that his client can do the job. If he can't do the job, the results may, of course, be anti-therapeutic and may lead to recidivism. It may create anxieties and result in his going back to the use of drugs. I think what is most important is that the man can do the job.
- I. Paul, what kinds of attitudes have you run into recently with employers? Do you tell employers, "This is an addict; yet he has the skill or training to do the job"?
- P. It depends on the type of job the client is going to do. Now, there are jobs where an employer isn't concerned as to whether a man is an addict or not. Some employers are a little more lenient in their attitudes about hiring ex-addicts or ex-convicts or people who have social problems. When this is the type of employer, we try to involve him in our approach of getting our client employed. We feel this type of employer can be a definite help in assisting our client to do the job and remain drug free. If the employer is the type who doesn't understand the problem, we take a chance. The main thing is to get the client actively involved in something that is profitable for

him and society.

I From time to time we hear that a teenager uses the addiction as a means of "getting authority," that is, parents, teachers, police, etc., that he is really guarded in his use and has no intention of becoming an addict. Could you tell us about this?

P Well, I don't understand a lot of young people myself. There is a generation gap with me, too. I know of some young people who are becoming, instead of drug-oriented, revolution-oriented. And some might, of the two, rather see them get involved in drugs. We've had patients who because of the use of drugs calmed down and became less of a threat to society. But I do believe a lot of young people use drugs and attempt to shake up society and the establishment and their parents.

I Paul, what are your recommendations to a rehabilitation counselor working with an addict?

P Well, it's very unfortunate that the counselor can't really involve himself in the sub-culture that the addict comes from so that he can really know the life style of the addicts he works with. There are different types of addicts, but one thing they do have in common is that they all involve themselves in the same sub-cultural activities. If the counselor could, unknown to the addicts, mingle with them on their own grounds, I think that he could have a better idea of how to help them.

I Thank you, Paul, for the interview and for being so forthright with us. I think these many things we have discussed will be helpful to the vocational rehabilitation counselor.

APPENDIX D

DRUG GLOSSARY

A	the amphetamines, any amphetamine, methedrine
A-head	frequent or regular user of the amphetamines or methedrine
Acapulco gold	a superior and powerful form of marijuana, said to grow in the Acapulco region of Mexico, often, any strong marijuana
Acid	LSD, LSD-25 (lysergic acid diethylamide)
Acid freak	chronic and frequent user of LSD
Acid head	more or less regular user of LSD
Acid rock	music influenced by the psychedelic experience or thinking process
Amys	vials of amyl nitrite, a vasodilator
Bad trip	a panic reaction, or psychosis after taking a hallucinogen, especially LSD
Bag	(1) a quantity of drugs, for marijuana users, a "nickel bag", for heroin addicts, a quantity of heroin, for amphetamine users, a quantity of methedrine, (2) a mood, a direction, an emphasis, style or taste
Ball	Absorption of stimulants and cocaine via genitalia
Bang	(1) sudden, sensual flush of pleasure as an intravenously injected drug--heroin or methedrine, usually--begins to take effect, (2) to have sexual intercourse
Barbs	barbiturates
Beat	to rob or cheat one out of money or goods
Behind	(1) under the influence of a drug, as in "I hallucinated behind acid", (2) to be addicted to a drug, "That cat's strung out behind H."
Bennies	benzedrine, an amphetamine
Bent	high or intoxicated from a drug
Bindle	packet of narcotics
Bit	time served in jail
Blank	extremely low-grade narcotics
Blast	to smoke marijuana (an obsolete term) or the strong effect from a drug
Blind	to be under the influence of a drug, often marijuana, to such an extent that one is unable to function normally
Blow	to inhale heroin or cocaine through the nose
Blue angels	Amytal, a barbiturate
Blue velvet	Paregoric (camphorated tincture of opium) and Pyribenza- mine (an antihistamine) mixed and injected

Bombita	Amphetamine injection, sometimes taken with heroin
Boo	marijuana, although generally obsolete, sometimes used humorously
Boss	authority or domination of drug, good quality
Bread	money
Brick	a block of marijuana, compressed and packaged, usually a kilogram in weight, although sometimes slightly less
Bring down	to lose one's high, anything which causes one to lose one's high, that which causes one to lose any positive euphoric feeling, anything which is depressing
Bum trip, bummer	a negative or unpleasant experience with a psychedelic drug, generally, any unpleasant experience
Burn	to sell someone else a quantity of drugs, and not deliver them, or give adulterated drugs
Bust	to arrest
Buttons	the sections of the peyote cactus
Buzz	a slight tingle of a drug feeling, used especially with marijuana, "I just got a buzz from that joint."
Can	a quantity of marijuana, slightly more than one ounce, more often used in some geographical locales than others--Chicago, for instance (see "lid")
Cap	a capsule of a drug, usually LSD
Carrying	to be in possession of a drug
Chipping	taking narcotics occasionally
Chippy	to use an addicting drug, usually heroin, sporadically, so that one does not become addicted
Clean	(1) to prepare marijuana for smoking by removing stems, twigs, and seeds, (2) not to be in legal possession of any drug, so that when the police search one's dwelling or person, no drugs will be found, (3) among addicts abstention from an addicting drug
Coasting	under the influence of drugs
Cocktail	a "roach" or a small amount of marijuana or hashish twisted into a regular tobacco cigarette
Coke	cocaine
Cokie	cocaine addict
Cold	sudden withdrawal of narcotics (from the gooseflesh, which resembles the skin of a cold plucked turkey)
turkey	
Come down	see "bring down," recovering from a trip
Connection	drug supplier or source
Cook	to heat the mixture of heroin, to dissolve
Cop	to obtain or buy a quantity of drugs--see "score", generally, to obtain anything

Cop out	quit, take off, confess, defect, inform
Crash	to "come down" from the long-term effects of the amphetamines
Crash pad	place where the user withdraws from amphetamines
Crutch	a device, often a folded matchbook, used for holding a burned-down marijuana cigarette butt (see "roach") to prevent one's fingers from being burned, a "roach holder"
Crystal	methedrine
Cubehead	frequent user of LSD
Cut	dilute drugs by adding milk sugar or another inert substance
Deal	to sell drugs
Dealer	a seller of drugs, usually on a large scale commercial basis
Deck	packet of narcotics
Dexies	dexedrine, an amphetamine
Dime bag	ten dollars worth of a drug
Dirty	possessing drugs, liable to arrest if searched
Do	to take a drug, see "make"
Dollies	Dolophine (also known as methadone), a synthetic narcotic
Doojee	heroin, also spelled dugie, duji
Dope	humorous term used by drug users for drugs, usually marijuana "I smoke dope", often heroin
Doper	person who uses drugs regularly
Downs	barbiturates or tranquilizers
Down	anything depressing
Dried out	detoxified, withdrawn from a drug
Drop	swallow a drug
Dummy	purchase which did not contain narcotics
Dynamite	an exceptionally powerful and pure quantity of a drug, "That's dynamite grass", often denotes anything exceptionally good
Factory	clandestine location for processing illicit drugs
Fall out	to go to sleep, often after taking a drug
Fed	a federal narcotics agent
Fiend	see "freak"
Fix	injection of narcotics
Flash	see "rush"
Flip	become psychotic
Floating	under the influence of drugs

Freak	a chronic and heavy user of a drug, never marijuana, the term has a distinctly negative connotation
Freak out	to have a psychotic experience with a psychedelic drug
Front	false display of respectability
Fuzz	the police
Gage	obsolete (sometimes humorously used) term for marijuana
Garbage	weak, heavily diluted heroin
Good trip	happy experience with psychedelics
G.B.	goofballs, barbiturates
Grass	marijuana
Gold	see "Acapulco gold"
Guide	someone who accompanies a person taking an LSD "trip"
H	heroin
Habit	being physically dependent upon a drug
Hard	opiates, such as heroin and morphine
narcotics	
Hard stuff	heroin
Hash	hashish, the resin of Cannabis
Hay	marijuana
Head	(1) user of a drug, contains no negative connotation, (2) mood, thoughts, opinion, taste, "Where's your head at?"
Hearts	dexedrine tablets (from the shape)
Heat	the police
High	to be under the influence of a drug
Holding	having the influence of drugs
Hooked	addicted
Hophead	narcotics addict
Horse	heroin
Hot shot	overdose of heroin, or poison
Hustle	activities involved in obtaining money to buy heroin
Hustler	prostitute
Hype	narcotics addict
Joint	marijuana cigarette
Jolly pop	pep pills
beans	
Jones	habit or addiction
Joy-pop	inject narcotics irregularly
Junkie	narcotics addict
Key, k1	a kilogram, usually of marijuana (or sometimes hashish)

Kick the habit	stop using narcotics (from the withdrawal leg muscle twitches)
Kif	North African cannabis
Lay on	to give someone someone something, often a quantity of drugs "I laid some grass on the cat", could also mean to tell someone something
Layout	equipment for injecting drugs
Leapers	amphetamines
Lemonade	poor heroin
Lid	a quantity of marijuana, generally slightly more than an ounce, usually regionally distinctive for California and the West Coast
M	morphine
Mainline	inject drugs into a vein
Maintain- ing	keeping at a certain level of drug effect
(The) Man	the police
Make	(1) to take a certain drug, to have experience with a specific drug, as in "Did you ever make acid"? (2) to have sexual intercourse
Manicure	remove the dirt, seeds, and stems from marijuana
Mesc	mescaline, the alkaloid in peyote
Meth	methamphetamine (also known as Methedrine, Desoxyn)
Methhead	habitual user of methamphetamine
Mikes	micrograms (millionths of a gram)
Mary Jane	an obsolete term for marijuana, sometimes used in jest
Nark, Narco	narcotics agent
Nickel bag	five dollars worth of a drug, often marijuana
Nod, nod out, go on the nod	to become extremely lethargic and sleepy under the influence of a narcotic drug, usually heroin
O	opium
O.D.	to take an overdose of a drug (never marijuana), usually heroin
O.Z.	an ounce, usually marijuana
Panama Red	powerful form of marijuana, usually coming from Panama
Panic	the general unavailability of a drug in a given area
Pillhead	heavy user of pills, barbiturates or amphetamines or both

Pod	obsolete term for marijuana
Poison	heroin
Poke	(1) a puff of marijuana (2) the jab of a needle into one's skin
Pop	inject drugs
Popped	to be arrested by the police
Poppers	vials of amyl nitrite
Pot	marijuana
Pothead	heavy marijuana user
Pound	\$5
Prince Albert	a quantity of marijuana, or a "can," so-called because it was once put into an empty Prince Albert pipe tobacco can
Psychedelic	having the quality of "expanding" the mind
Pure	relatively undiluted heroin
Purple hearts	dexamyl, a combination of dexedrine and amytal (from the shape and color)
Pusher	obsolete term for a seller of drugs
Quarter Bag	1 ounce of marijuana, worth \$25
Quill	a matchbook cover for sniffing Methedrine, cocaine, or heroin. see "crutch"
Rainbows	Tuinal (Amytal and Seconal), a barbiturate combination in a blue and red capsule
Rap	to talk or speak
Red devils	Seconal, a barbiturate
Reefer	marijuana cigarette
Reentry	return from a trip
Roach	marijuana butt
Roach holder	device for holding the butt of a marijuana cigarette
Run	an amphetamine binge
Rush	the sensuous feeling of an injected drug
Satch cotton	cotton used to strain drugs before injection, may be used again if supplies are gone
Scag	heroin
Scene	where the action is, a place to be
Scoff	(1) to swallow a drug orally (2) to eat
Scoop	a makeshift object to sniff cocaine or heroin (matchbook)
Score	(1) to obtain a quantity of a drug, see "cop", (2) the quantity of drugs that one obtains, (3) have sexual intercourse

Shit	any drug, but usually heroin, occasionally, marijuana
Shooting gallery	place where addicts inject
Skin popping	to inject a drug subcutaneously, rather than intravenously, usually to avoid addiction
Smack	heroin
Smoke	marijuana or wood alcohol
Snappers	vials of amyl nitrite
Snort	to inhale a drug sharply through one's nostril, used with heroin and methedrine among the less frequent users (the heavier users more often inject the drug), and almost always with cocaine
Snow	often heroin, sometimes cocaine
Spaced out	to be high
Speed	usually methedrine, but can be any of the amphetamines
Speedball	an injection of a stimulant and a depressant, originally heroin and cocaine
Speed-freak	habitual user of speed
Spike	a hypodermic needle
Split	to leave
Spoon	(1) a level teaspoon of a drug, usually methedrine, (2) the device used to hold heroin or methedrine while it is being heated and liquified in preparation for intravenous hypodermic injection
Stash	a quantity of any drug that is hidden, generally, an amount of a drug
Stoned	to be very high
Stone	superlative, completely, absolutely, the ultimate
Stick	obsolete term for "joint" or a marijuana cigarette
Stoolie	informer
Strung out	addicted
Stuff	narcotics, usually heroin
Tab	a tablet of a drug, usually LSD
Taste	a small amount of a drug, often given in exchange for a favor, or as a sample
Take off	(1) see "get off", (2) to steal a quantity of drugs
Tea	somewhat lighthearted term for marijuana
Throw rocks	commit crimes
Toke	a puff of marijuana (sometimes opium)
Tools	equipment for injecting drugs
Tracks	scars along veins after many injections
Trey	a three dollar quantity of a drug

Trip	a psychedelic drug experience, generally any involved and dramatic experience
Turn on	(1) to take a drug, (2) to take a drug for the first time, almost always marijuana, (3) to become high for the first time, usually on marijuana, (4) generally, to introduce or sensitize someone to something
Turps	elixir of Terpin Hydrate with codeine, a cough syrup
25	LSD (from its original designation, LSD-25)
Ups, uppers	stimulants, almost always the amphetamines
Using	taking drugs
Waste	destroy
Wasted	to be under the influence of a drug to such an extent that one is able to do little else but rest or sleep
Weed	marijuana
Weight	a large quantity of a drug, usually marijuana, often for selling purposes, "I'm looking to cop weight."
Wiped out	see "wasted"
Wig	an insane person
Wig out	to have a psychotic episode under the influence of a psychedelic drug; see "freak-out," "flip out"
Works	the equipment used to inject drugs intravenously, the needle, especially
Yard	\$100
Yellow jacket	nembutal, a barbiturate
Yen sleep	a drowsy, restless state during the withdrawal period
Zonked zonked out	see "wasted" generally, also, to be tired

APPENDIX E

Confidentiality of the Records
Of The
Vocational Rehabilitation Agency

The State Vocational Rehabilitation Agency may on occasion be served with a subpoena for disclosure of information in agency files relating to Drug Abuse Clients. Where disclosure in response to such subpoena would not be for a purpose directly connected with the Administration of a Vocational Rehabilitation Program and the Drug Abuse Client has not consented to the release of information, Section 401.39 of the Regulations and relevant State Plan Provisions would prohibit such disclosure

Should the State Agency accede to the subpoena by producing the case files, the Agency would then be in direct violation of the Federal regulation relating to confidentiality. The Agency may also be violating applicable State statutes since the basic State Vocational Rehabilitation Act contains an all-inclusive acceptance provision relating to the Federal legal requirements. In the event that the State Agency is served with a subpoena, assistance should be sought from the State Attorney General's office to obtain relief from the subpoena. If the subpoena is allowed to stand, it is suggested that the State Agency representative be accompanied to court by a member of the Attorney General's office. Upon being called to produce Agency records, relief would be requested again since the disclosure would be in clear violation of the Federal and State legal provisions governing the operations of the Federal-State Vocational Rehabilitation Program. Failing in this, the State Agency should rely on the advice of the Attorney General's office as to what action should be taken.

APPENDIX F

IRS PRIME STUDY GROUP I
THE REHABILITATION OF THE DRUG ABUSER
QUESTIONNAIRE

STATE _____

Statistical study of drug abusers non-rehabilitated (NR, 08, 30, 28) and rehabilitated (R, 26)* by State VR Agencies for the fiscal years 1967, 68, and 1969.

1. REFERRAL SOURCES

	1967		1968		1969	
	Number		Number		Number	
	NR	R	NR	R	NR	R
Hospitals and Sanatoriums						
Other Health Agencies						
Welfare Agencies						
State Employment Service						
Individual, Except Client						
Self-Referred Persons						
Correctional Institutions						
Other Sources						

2. AGE

	1967		1968		1969	
	Number		Number		Number	
	NR	R	NR	R	NR	R
14-19 yrs.						
20-24						
25-29						
30-34						
35-39						
40-44						
45-54						
55 and over						

3. SEX

	1967		1968		1969	
	Number		Number		Number	
	NR	R	NR	R	NR	R
Male						
Female						

*In referring to 26 Closures we are interested only in those with the major disability of "drug abuser" (or 521)

4. The number of referrals with disabilities reported as drug abuse or 521.

1967
Number

1968
Number

1969
Number

- 5 RACE

1967
Number
NR | R

1968
Number
NR | R

1969
Number
NR | R

Caucasian
Negro

6. Number of referrals with a disability as reported drug abuse or 521 closed at the status 08.

1967
Number

1968
Number

1969
Number

7. The number of clients with the major disability of drug abuse or 521.

1967
Number
NR | R

1968
Number
NR | R

1969
Number
NR | R

8. The number of clients with the secondary disability of drug abuse or 521.

1967
Number
NR | R

1968
Number
NR | R

1969
Number
NR | R

9. MARITAL STATUS

	1967 Number		1968 Number		1969 Number	
	NR	R	NR	R	NR	R
Married						
Widowed						
Divorced						
Separated						
Never Married						

10. EDUCATION

	1967 Number		1968 Number		1969 Number	
	NR	R	NR	R	NR	R
Grade Completed						
1-7						
8						
9-11						
12						
13-15						
16 and over						
Special Education						

11. MONTHLY FAMILY INCOME

	1967 Number		1968 Number		1969 Number	
	NR	R	NR	R	NR	R
0.00-199.99						
200.00-299.00						
300.00-399.00						
400.00-499.00						
500.00-599 00						
600.00 and over						

- 12 How many of the client - drug abusers received case service with cost to your State Rehabilitation Agency? 1967____, 1978____, 1969____.

Of this number, what were the percentages receiving specific types of services?

Services	1967 Percentage	1968 Percentage	1969 Percentage
Diagnostic			
Physical Restoration			
Training			
Maintenance & Transportation			

13. How many client - drug abusers were closed at Status 28 or 30?

1967 Number		1968 Number		1969 Number	
28	30	28	30	28	30

14. Can a client in your State be accepted for VR services with a primary disability of drug abuse without any written diagnosis of a behavior or psychiatric disability? (Yes, No) any comments? _____
- _____

15. Can a client in your State be accepted for VR services with disability of drug abuse in remission? (Yes, No) any comments? _____
- _____
- _____
- _____
- _____

**16. Does your State operate any facility which works directly with the rehabilitation of the drug abuser? (Yes, No) If so, who has the responsibility for its operation? _____

**17. If your agency is not responsible for the operation of such a facility, then does your agency formally participate in it? (Yes, No). In which do you participate?

To what extent does your agency participate? _____

**18. Does your agency formally participate in any private facility (i.e., therapeutic community, half-way house, free clinics) that work with the drug abuser? (Yes, No) In which do you participate? _____

To what extent does your agency participate? _____

**For questions 16, 17, and 18, if you have any information regarding such facilities, please forward copies of such information with this questionnaire.

19. Does your State agency have counselors with a specialized case-load working only with drug abusers? (Yes, NO)

The following three questions are aimed at the counselors who work with the drug abuser. If possible, it would be appreciated if you could get a sampling of responses from them or of some person working closely with them.

1. Do you have any specialized training in working with the drug abuser? (Yes, No). If so, please indicate.

2. When working with the drug abuser, do you find that counseling is often the most important service rendered? (Yes, No) _____

If not--what is? _____

3. When working with the drug abuser, do you require, or highly recommend the client to be involved with some facility which directly works with drug abuser while he is receiving services from V.R.? (Yes, No) _____

Any comments? _____

APPENDIX F (1)

SUMMATION OF
THE REHABILITATION OF THE DRUG ABUSER
QUESTIONNAIRE

In an attempt to compile information regarding the current role of State VR agencies in their work with the drug abuser, a questionnaire was sent to each of the states. The percentage of returns was high -- 80%, the data, however, is inconclusive. The reasons for the inconclusive data are best stated in comments from many of the letters included with the returned questionnaires

Before sharing some of these comments, it is important to note one significant point which emerged from the data most of the state VR agencies are working with drug abusers What obscures the data is the manner in which the states accept and classify a client who is a drug abuser The following comments illustrate this point

- 1 "I regret to report that Items 1 through 13 cannot be completed We show no drug abusers in our caseloads through 1969 This is not say that we have none. I would suspect that there were some, and that their disabilities were disguised under one of the character behavior or psychiatric disability categories

"Items 14 through 19 would be answered 'No ' Again, I suspect that there are a few drug abusers in our caseloads known to the counselors but not reflected in our statistical data "

2. "The closest we come to collecting information on Drug Abusers is Drug Addicts (Code 521 in the VR Manual)."
- 3 "We enjoyed reviewing and completing as much of the questionnaire on drug abuse as was possible. We have noticed a substantial increase in drug abuse referrals in the past three years and we feel this disability deserves our special attention

"Unfortunately, the data you requested regarding code 521, drug addiction, is not available presently in our data system For instance, during fiscal year 1969-70, only four cases were coded as 521, although our work with the drug abuser increased dramatically. This discrepancy can be explained easily by understanding that the agency Manual of Policies had no clear guidance on how to work with the drug abuser. Therefore, counselors coded these cases according to psychological condition, such as 522, personality disorder, 500, psychotic, or 510, psychoneurotic.

"A manual revision this fiscal year included a section on drug abuse and addiction and we anticipate more use of code 521. However, it will be at least June of 1972 before any reliable data can be pulled from our data system."

4. "We would like to call attention to the point that many cases have been served by the Agency which have a drug abuse problem but have been coded under the disability code of character, personality and behavior disorder, code 522, rather than drug addiction 521. We feel this is probably true in many states because of the eligibility determination provisions and regulations."
5. "Questions 1 through 13 of the attached questionnaire remain blank since our Agency, at this time, has not categorically served the drug abuser, or at least our records do not enable us to make such categorical identification."

Another factor which obscures the data appears to be attitudinal and is one with which the states must come to grips. The following excerpts illustrate this point

6. "The only report we can presently provide concerns addiction. We do not have a definition of drug abuse locally or from the RSA for legally determining eligibility for DVR services. The simple use or abuse of drugs of itself cannot qualify an individual for DVR services.

"Our principal emphasis is rehabilitation, not prevention, and as such makes our services inappropriate for most of the problems usually associated with drug abuse. On the other hand, the hard core addict who is on hard drugs is a poor risk for services delivered in the community. We are not equipped with the resources or techniques for dealing with a counter-culture that spurns work and 'the system.' Seen as a consequence of the aforementioned, the number of addicts with whom we work is quite small, and no dramatic increase in the program is anticipated."

7. "I have deliberately held the questionnaire hoping that we could come up with something that might be of significant help to your group but, as you can see from the statistics that we have gathered for the past fiscal year, we have not

yet initiated a program here and gained information which will be helpful at this time."

8. "The above information is scanty at the best, however, real assistance to other than the hard drug users has not been a prominent part of our program. We have worked with drug users since the inception of our mental service program. However, in the many years I have been associated with Vocational Rehabilitation, we have not been able to realize the complete rehabilitation of any client who has been a mainliner."
9. "This state has not made a concentrated effort to serve this particular group so our figures would be few in number. We also suspect that some drug abusers were probably coded 522 instead of 521, so, there is a further problem of identification."

A third problem in the collection of data is mechanical and is best stated by the following

10. "The information you request is either nonretrievable, not available, or terribly time-consuming to obtain. I have, however, made some very rough guesses."
11. "I have attempted to complete the questionnaire on drug abuse, however, for the most part it was found that the information was not retrievable."
12. "We are sorry to be so late in returning the questionnaire, however, we have tried very diligently to get as much of the numerical information you requested as possible. As you can tell, we were not terribly successful in getting a great deal of the information relative to the number of drug abusers served by our agency."
13. "After reviewing the enclosed questionnaire, I find that, for our own Agency, the major portion of the requested material is not retrievable. I regret that more substantial information cannot be provided."
14. "Much of the information requested on the survey form is not readily available from our records. I am sure other state

agencies will have the same problem in replying to the questionnaire and particularly those areas where statistical information is required. We do not have the type of statistical reporting wherein this data could be readily retrieved."

15. "Rehabilitation has but few clients with the primary disability of drug abuse. These are spread throughout the state and it would require a long and diligent search to find pertinent statistics on them."

16. "I have attempted to complete the questionnaire on drug abuse, however, for the most part it was found that the information was not retrievable."

As was stated earlier in this section, the one point which did emerge from the data is that the state VR agencies are working with the drug abuser--even though he is assigned to many different disability categories. There is evidence, however, that some states are looking at "drug abuse" as a distinct category

17. "As the drug abuse program is relatively new to this state's Division of Vocational Rehabilitation, and we have only had drug abuse clients since fiscal year 1968, we will furnish the information for fiscal years 1968, 1969, 1970 on your questionnaire "

18. "As a matter of fact it is only within the current year that we have had any clients on our rolls for whom 'drug abuse' was listed as the cause of disability "

19. "We are very interested in the outcome of your Study Group, as we are beginning to enter into the provision of vocational rehabilitation services to the drug misuser on a statewide basis "

Hopefully, this last comment will develop into a national trend

APPENDIX G

A TRAINING GUIDE

A training program for State agency personnel on the Rehabilitation of the Drug Abuser should have a dual focus of information and insight. It is essential, of course, for the rehabilitation counselor to be informed about drugs and drug abusers, it is equally important that he acquire insight into his own attitudes, feelings, and prejudices toward drug abusers. For these objectives to be attained, the training program should be a continuous one.

While being fully appreciative of the State agency's responsibility for servicing other disability groups and for case loads whose demands impose time constraints on State training programs, the Prime Study Committee believes that a commitment to service the drug abuser requires minimally a two-day training session followed by a second two-day session after a six-month interval. The first of the two-day sessions should focus primarily on information and begin to explore attitudes and feelings. The second training conference should ascertain the extent to which the information has become part of the "working knowledge" of the counselors and then place its major emphasis on counselor attitudes and feelings in working with the drug abuser.

Both training conferences should foster within the counselor positive attitudes toward the drug abuser and lead to a willingness to service this disabled population.

Outline for the First Two-Day Training Conference

This suggested training guide is for the first of the two-day conferences. At least two weeks prior to the conference, a copy of this publication, Rehabilitation of the Drug Abuser, might be sent to each of the participants so as to provide some basic information.

FIRST DAY

Morning Session

1. Over-view of conference objectives (with emphasis on positive aspects of working with drug abuser).
2. Client's perception of the drug abuse problem and DVR services. (An articulate drug abuser who has been rehabilitated would serve as an excellent keynote speaker and help set the "tone" of the conference).

3. Coffee break. (At this point a coffee break enables participants to discuss informally the conference objectives as well as the keynote presentation).
4. Formal presentation of Chapter I, "Nature and Extent of Drug Abuse." (It is important that the speaker be knowledgeable in the pharmacological aspects of drug abuse. The presentation should emphasize the distinction between "types" of drugs as well as the physical and psychological effects possible from each).
5. Small group discussion of Chapter I and formal presentation. (The group leader should be skilled in group dynamics so as to elicit discussion. The discussion should attempt to assess the extent to which the participants understand the nature of drugs and the degree to which they perceive their own attitudes toward drug abusers).
6. Lunch. (Ample time should be provided for informal discussion).

Afternoon Session

1. Formal presentation of Chapter II, "Evolution of Drug Abuse Legislation," and Chapter III, "Eligibility and Feasibility." (The speaker should stress the change in societal attitudes from punitive to rehabilitative. Emphasized should be (1) current legislation as it applies to eligibility and feasibility, and (2) interagency cooperation).
2. Small group discussion of Chapters II and III and formal presentations. (These chapters offer an excellent opportunity to explore the attitudes of participants. The group leader should note to what extent the participants are in agreement with current legislation and what proposals emerge from the discussion).

SECOND SESSION

Morning Session

1. Formal presentation of Chapter IV, "Differential

Aspects of Client Study," and Chapter V, "Staff Attitudes and Counselor Skills." (The speaker should be knowledgeable on a first-hand basis. Counselors within the agency who are working with drug abusers should be asked to share their experiences. This should be a planned sharing and not spontaneous).

2. Small group discussion of Chapters IV and V and formal presentations. (Participants should be encouraged to explore their feelings regarding the drug abuser. Usually, "role playing" is effective as a means of facilitating discussion of counselor attitudes and feelings).

Afternoon Session

1 Formal presentation of Chapter VI, "Service Programming." (A discussion of treatment modalities should avoid a qualitative judgment as to which type is best. The emphasis should be on an understanding of the rationale for each type. Placement is a major part of this chapter and is central to the rehabilitation process. The special problems in placement should be presented with a positive emphasis)

2. Small group discussion of Chapter V (Role playing is an effective vehicle for presenting problems and approaches in the placement of the drug abuser).

Summary Session

It is desirable to have a conference summary which focuses on the feelings and attitudes of the participants. Two or three persons should be assigned to the exclusive responsibility of circulating among the discussion groups and of sampling feelings and attitudes of the participants. The conference should conclude on the theme "Where do we go from here"?

NOTE

As a follow-up to this conference the participants should be encouraged to visit drug treatment programs and to become better acquainted with drug abusers. To the extent that it is possible, the

visits should be planned and supervised. The counselor should be provided an opportunity to ask questions and discuss feelings. A knowledgeable person should be available to provide the necessary assistance.

APPENDIX H

SCHEMA FOR EXAMINING JOB READINESS*

A. Physical readiness

1. Is client at his maximum level of physical capacity?
2. Can client travel to and from a job?
3. Can client meet the physical demands of the kind of work sought?

B. Psychological readiness

1. Do client and his family accept his limitations?
2. Do client and his family recognize his capabilities?
3. Is client sincerely motivated toward employment?
4. Can he adjust to the strains and pressures of a work environment?

C. Occupational readiness

1. Are client's aptitudes, skills, knowledge, and experience commensurate with job requirements, current and future?
2. Is the client really interested in job under consideration?
3. Are the job's non-monetary, psychological rewards in keeping with client's needs, values, and long-range goals?
4. Is client aware of opportunities and requirements for entrance to other jobs or tasks?

D. Placement readiness

1. To what extent can client participate in job-finding process?
2. Does client know sources of job leads?
3. Can he develop a personal information packet?
4. Can he satisfactorily complete an application?
5. Can he present himself adequately in job interview?

The extent of the evaluation suggested in the above schema is admittedly time consuming, even recognizing that much of the information required is accrued in previous stages of the rehabilitation process. Its eminent virtue, however, from the point of employer-agency relationships is the ability to "sell" the employer a qualified job applicant as a selective placement.

*Louis Vieceli, Placement of the Blind in Competitive Employment, Unpublished paper.

APPENDIX I

SELECTED FILMS

I. Listings of Drug Films (With Evaluations)

DRUG ABUSE FILMS

Prepared by the National Coordinating Council on Drug Abuse Education and Information, Inc., under contract to the National Institute of Mental Health, 1211 Connecticut Avenue, N.W., Suite 212, Washington, D. C. 20036. A 46-page review of nearly 100 titles of drug education films and other audio-visual materials. Copies of the evaluation are available from the Council at \$2.00.

SELECTED DRUG ABUSE EDUCATION FILMS

Prepared by the National Clearinghouse for Drug Abuse Information, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 12-page booklet at 10 cents a copy.

ANNOTATED LISTING OF DRUG ABUSE FILMS

From the RESOURCE BOOK FOR DRUG ABUSE EDUCATION prepared by the U.S. Department of Health, Education, and Welfare, National Institute of Mental Health, Chevy Chase, Maryland 20015. October, 1969 issue, pages 95-98.

PROJECT D.A.R.E.

University of California at Los Angeles, Los Angeles, California. A list of films rated "good" or "excellent" by student viewers.

II. Selected Films

1. Almost Everyone Does - Scenes from an "average" middle-class family illustrate what some people do to get rid of bad feelings. The film asks, "When does a drug that changes the way a person feels become harmful or dangerous?" Contact Gene Feldman, Wombat Productions, 87 Main St., Hastings-on-Hudson, N.Y. 10706

2. Darkness, Darkness - The film listens to a dozen people, all middle-class whites, whose lives in some way have been touched by heroin. Contact Nolan, Wilton and Wootten, Inc., 374 Waverley St., Palo Alto, Calif. 94301
3. A Day in the Death of Donny B. - The film portrays what could be a typical day in the life of a heroin addict in a ghetto slum. Contact National Audiovisual Center (GSA), Washington, D.C. 20409
4. The Distant Drummer - Paul Newman narrates this edited version of two shorter films, "Flowers of Darkness" and "The Movable Scene." Beginning with a historical perspective of the origin of opium, the film discusses opium's refinement to a morphine base and to heroin. It traces the import route of heroin from the Far East to Mexico and the United States, along with the accompanying price rise. Several rehabilitation techniques are briefly discussed against a review of Federal rehabilitation laws. The film focuses on the use of drugs by young, rebellious, middle-class Americans. Spontaneous interviews with drug users depict the drug scene in San Francisco, New Orleans and New York, as well as in several foreign cities. Contact National Audiovisual Center (GSA), Washington, D.C. 20409
5. Drug Abuse Everybody's Hang-up - This film, which takes a documentary-like look at the "drug scene," is designed to heighten awareness of, and concern with, the problem of drug abuse. It does not attempt to provide answers, but does offer some suggestions that may help keep children off the chemical road to nowhere and narrow the "generation gap." Contact Smith Kline & French Laboratories, 1500 Spring Garden St., Philadelphia, Pa. 19101
6. Drugs and the Nervous System - Particularly appropriate for junior high school students, this beautifully filmed presentation discusses basic facts about misuse of airplane glue, stimulants, depressants, marijuana and LSD. The major portion of the film explains the serious disruption of the nervous system caused by using these substances for "kicks." The film emphasizes the dangers of drug abuse without sermonizing. Enhanced by a good musical score and animation. Contact Churchill Films, 662 N. Robertson Blvd., Los Angeles, Calif. 90069

7. Drugs Are Like That - The film says that some drugs can make you feel funny, can make you look stupid, are against the law, and don't always do what they look like they'll do. Contact Junior League of Miami, Inc., 201 Douglas Village, 800 Douglas Rd., Coral Gables, Fla. 33134
8. Escape to Nowhere - The camera travels with Debbie, a 16-year-old addict, moving through her lonely world as she describes how she started on drugs and reveals the futility of her present existence. Contact Professional Arts, Inc., P. O. Box 8484, Universal City, Calif. 91608
9. Grooving - The film focuses on a group of teenagers - drug users, ex-users and non-users - who explore and evaluate reasons behind drug use. Contact Myron Solin, Benchmark Films, Inc., 145 Scarborough Rd., Briarcliff, N.Y. 10510
10. Help - Live scenes filmed at a hot-line crisis center in Philadelphia portray the staff in action as they offer telephone counseling, give medical examinations or trace potential suicide calls. Contact Concept Films, Suite 312, 1155 15th St., N.W., Washington, D.C. 20005
11. Hide and Seek - Film depicts, with excellent photographic technique, the anguish and despair of a teen-ager caught by the narcotic habit and unable to shake it. The real-life addict narrates his helplessness and the realization that he has unwittingly committed himself to a joyless and hopeless existence. The events shown in the film are actual experiences. Contact Center for Mass Communication, Columbia University Press, 440 W. 110th St., New York, N. Y. 10025
12. Hooked - Young people, ages 18 to 25, in what appears to be a security institution, describe experiences with drugs. The descriptions are uninhibited, sometimes shocking, and make frequent use of addicts' jargon. The young people speak with candor about what impelled them to use drugs, how drug abuse affected relationships with others, and the disgust with which they now regard their drug experiences. Contact Churchill Films, 662 N. Robertson Blvd., Los Angeles, Calif. 90069
13. I Think - The film illustrates how expectations of parents, teachers and peers help form attitudes, and how attitudes determine actions. Contact Gene Feldman, Wombat Productions, 87 Main St., Hastings-on-Hudson, N.Y. 10706

14. LSD-25 - This film which provides a current, accurate and balanced view of LSD use, emphasizes the unpredictability of the drug and its terrifying power. It succeeds in discouraging LSD experimentation without adopting a "preachy" tone. It is also superior from a visual and technical point of view, and should hold the interest of the most sophisticated audiences. Contact Professional Arts, Inc., P.O. Box 8484, Universal City, Calif. 91608
15. Marijuana - This CBS documentary surveys the controversy over the social and legal aspects of marijuana use. Contact Carousel Films, Inc., 1501 Broadway, New York 10036
16. Narcotics - Why Not - This film presents extemporaneous interviews with male and female residents of the California Rehabilitation Center. Both teen-agers and young adults relate how they started using glue, stimulants and depressants, marijuana and heroin. They tell what it is like to be under the influence of dangerous drugs, discuss their regrets, and examine hopes for the future. The realistic film has impact that could not have been achieved by using actors. Contact Aims Instructional Media Services, P.O. Box 1010, Hollywood, Calif. 90028
17. A Nice Kid Like You - Students from two unidentified eastern colleges reveal their feelings about drugs, sex, parents, the education system and American society in general. Contact Extension Media Center, University of California, Berkeley, Calif. 94720
18. Scag - The film relates the addiction experiences of a middle-class white male and an inner-city black girl, traces the import route of heroin into this country and focuses on several rehabilitation facilities and methods. Contact Concept Films, Suite 312, 1155 15th St., N W. Washington, D.C. 20005
19. Skezag - Wayne, a 21-year-old black living in New York City, talks at length about a variety of topics, including the Vietnam war, his use of heroin, why he won't become addicted, his attitude towards his mother, his friends and the white race. Contact Cinnamon Productions, Inc., 508 Broadway, New York, N. Y. 10012
20. Speedscene: The Problem of Amphetamine Abuse - The film presents evidence against use of amphetamines in any form for other than medical reasons. Contact James Ganzer, Bailey Film Associates, 2211 Michigan Ave., Santa Monica, Calif. 90404

21. Weed - The film covers the legal, historic and sociological aspects of marijuana use. Contact Concept Films, Suite 312, 1155 15th St., N.W., Washington, D.C. 20005

APPENDIX J

BIBLIOGRAPHY

In many of the references cited below there are extensive bibliographies, some of which are annotated. The intent of this bibliography is to suggest some basic sources to be used as a supplement to this document, The Rehabilitation of the Drug Abuser.

A Bibliography on Drug Dependence, compiled by Helen F. Sells, Fort Worth, Texas The Texas Christian University Press, 1967.

A Community Guide to Drug Abuse Action, Washington, D. C. National Coordinating Council on Drug Abuse Education and Information, Inc., 1970.

A Federal Source Book Answers to the Most Frequently Asked Questions About Drug Abuse, Washington, D.C. G.P.O., 1971.

Directory of Narcotic Addiction Treatment Agencies in the United States 1968-69, (Public Health Service Publication # 2095,) Washington, D. C. Superintendent of Documents, 1970.

Resource Book for Drug Abuse Education, Washington, D.C. National Clearinghouse for Mental Health Information, 1964.

A Guide to Some Drugs Which are Subject to Abuse, New York American Social Health Association, 1969.

Anslinger, H.J., and Tompkins, W.F., The Traffic in Narcotics, New York Funk and Wagnalls, 1953.

Barber, B., Drugs and Society, New York Russell Sage Foundation, 1967.

Blum, R.H. and associates, Utopiates The Use and Users of LSD-25, New York Atherton Press, 1964

Caplan, G., Principles of Psychiatry, New York Basic Books, Inc., 1964

Casriel, D., So Fair a House The Story of Synanon, Englewood Cliffs, N. J. 1963.

Chein, I., et al., The Road to H, New York Basic Books, Inc., 1964.

Cody, J.J., "Appraisal of Disadvantaged Youth," Counseling the Disadvantaged Youth, (W.E. Amos, ed.), New Jersey Prentice Hall, 1968.

Committee on Alcoholism and Addiction and Council on Mental Health, "Dependence on Amphetamines and Other Stimulant Drugs," Journal of the American Medical Association, 197: 1023-1027, 1966.

Committee on Alcoholism and Addiction, "Dependence on Barbiturates and Other Sedative Drugs," Journal of the American Medical Association, 193 673-677, 1965.

Diskind, M.H., "The Role of the Parole Officer on the Use of the Authoritative Case Work Approach," Rehabilitating the Narcotic Addict, Washington, D. C.· G.P.O., 1967.

Drug Abuse A Manual for Law Enforcement Officers, Philadelphia· Smith, Kline, and French Laboratories, 1966.

Drug Abuse A Primer for Parents, Washington, D.C.: National Education Association.

Drug Abuse Escape to Nowhere, Philadelphia: Smith, Kline and French Laboratories, 1970.

Drug Abuse· The Empty Life, Philadelphia Smith, Kline and French Laboratories, 1965.

Drug Addiction· Crime or Disease? Interim and Final Reports of the American Bar Association and the American Medical Association on Narcotic Drugs, Bloomington Indiana University Press, 1963.

Drug Abuse Education· A Guide for the Professions, Washington, D.C. American Pharmaceutical Association.

Drug Dependence· A Guide for Physicians, Chicago American Medical Association Order Department.

Eddy, N.B., et al., "Drug Dependence· Its Significance and Characteristics," Bulletin of the World Health Organization, 32 721-733, 1965.

Eldridge, W.B., Narcotics and the Law, New York New York University Press, 1962.

Food and Drug Administration, The Use and Misuse of Drugs, Publication # 46, Washington, D.C. G. P. O., 1968.

Goode, E., (ed.) Marijuana, New York. Atherton Press, 1970.

Kaplan, R., Drug Abuse: Perspectives on Drugs, Dubuque, Iowa Wm. C. Brown Co., 1970.

Kolb, L., Drug Addiction, Springfield, Ill., Charles C. Thomas, Publisher, 1962.

Lasagna, L., M.D., "Drugs Through the Ages," in The Medicated Society, edited by S. Proger, M.D., New York The Macmillan Co., 1968.

Laskowitz, D., "Psychological Characteristics of the Adolescent Addict," Drug Addiction in Youth, edited by E. Harms, New York Pergamon Press, 1965

Leshner, S.S., "The Relationship of Work Evaluation to Work Adjustment Training," Journal of Rehabilitation, 1970.

Lindesmith, A.A., The Addict and the Law, Bloomington. Indiana University Press, 1965.

LSD, Some Questions and Answers, (Publication #1828), Washington, D.C. Superintendent of Documents.

Marijuana, Some Questions and Answers (Publication #1829) Washington, D.C. Superintendent of Documents.

Mental Health Monograph 2 Narcotic Drug Addiction, Public Health Service Publication #1021, 1965.

Mental Health Monograph 3 Rehabilitation in Drug Addicts. A Report on a Five-Year Community Experiment of the New York Demonstration Center, Public Health Service Publication #1013, 1964.

Narcotics Some Questions and Answers, Publication #1827, Washington, D.C. Superintendent of Documents.

National Institute of Mental Health, Facts About Narcotic Drug Addiction, Public Health Service Publication #1322, Washington, D.C. Superintendent of Documents.

Nowlis, H.H., Drugs on the College Campus, New York. Anchor Books, 1969.

The President's Advisory Commission on Narcotic and Drug Abuse
Final Report, Washington, D.C. Superintendent of Documents, 1963.

Richman, S., "The Addict as a Rehabilitation Client,"
Rehabilitation Record, 1966.

Sinick, D., "Training, Job Placement, Follow-Up," The Vocational
Rehabilitation of the Disabled, (D. Malikin and H. Rusalem, ed.),
New York University Press, 1969.

Task Force on Narcotics and Drug Abuse, the President's Commission
on Law Enforcement and Administration of Justice, Task Force
Report: Narcotics and Drug Abuse, Washington, D.C.
Superintendent of Documents, 1967.

Trellis, E.S., M.D., "A Pilot Project in the Pittsburgh Area,"
Rehabilitating the Narcotic Addict, Washington, D.C.
Superintendent of Documents, 1967.

Weinswig, M.H., and Doerr, D.W., ed , Drug Abuse A Course for
Educators, Indianapolis Butler University, 1968.

Wiener, F., "Planning Aftercare Community Services,"
Rehabilitating the Narcotic Addict, Washington, D.C.
Superintendent of Documents, 1967.

Yablonsky, L., The Tunnel Back Synanon, New York Macmillan Co., 1965

APPENDIX K

DRUG ABUSE PRODUCTS REFERENCE CHART*

DRUGS	PHARMACOLOGIC CLASSIFICATION	MEDICAL USE	POTENTIAL FOR PHYSICAL DEPENDENCE
Morphine (an opium derivative)	Central Nervous System Depressant	To relieve pain	Yes
Heroin (a morphine derivative)	Depressant	To relieve pain	Yes
Codeine (an opium derivative)	Depressant	To relieve pain and coughing	Yes
Paregoric (preparation containing opium)	Depressant	For sedation and to counteract diarrhea	Yes
Meperidine (synthetic morphine-like drug)	Depressant	To relieve pain	Yes
Methadone (synthetic morphine-like drug)	Depressant	To relieve pain	Yes
Cocaine	Central Nervous System Stimulant	Local anesthetic	No
Marijuana	Hallucinogen	None	No
Barbiturates (e g ,amobarbital, pentobarbital, secobarbital)	Depressant	For sedation, sleep producing, epilepsy, high blood pressure	Yes
Amphetamine drugs (e g ,amphetamine, dextroamphetamine, methamphetamine-- also known as desoxyephedrine)	Stimulant	For mild depression, anti-appetite narcolepsy	No
LSD (also mescaline peyote, psilocybin, DMT, STP, THC)	Hallucinogen	(Medical research only)	No
Glue (also paint thinner, lighter fluid)	Depressant	None	Unknown

*Permission to reproduce this chart was granted by Smith, Kline and French Laboratories The original chart appears in Drug Abuse Escape to Nowhere

DRUG ABUSE PRODUCTS REFERENCE CHART CONTINUED

DRUGS	POTENTIAL FOR PSYCHOLOGICAL DEPENDENCE	TOLERANCE	POSSIBLE EFFECTS WHEN ABUSED	HOW TAKEN WHEN ABUSED
Morphine	Yes	Yes	Drowsiness, or stupor, pinpoint pupils	Orally or by injection
Heroin	Yes	Yes	Same as morphine	Sniffed or by injection
Codeine	Yes	Yes	Drowsiness, pinpoint pupils	Orally (usually as cough syrup)
Paregoric	Yes	Yes	Same as morphine	Orally or by injection
Meperidine	Yes	Yes	Similar to morph- ine, except that at higher doses, excitation, tremors and con- vulsions occur	Orally or by injection
Methadone	Yes	Yes	Same as morphine	Orally or by injection
Cocaine	Yes	No	Extreme excita- tion, tremors, hallucinations	Sniffed or by injection
Marijuana	Yes	No	Drowsiness or excitability dilated pupils, talkativeness, laughter, hallucinations	Smoked or orally
Barbiturates	Yes	Yes	Drowsiness, staggering, slurred speech	Orally or by injection
Amphetamine	Yes	Yes	Excitation, dilated pupils, tremors, talk- ativeness hallucinations	Orally or by injection
LSD	Yes	Yes	Excitation, hallucinations, rambling speech	Orally or by injection
Glue	Yes	Yes	Staggering, drowsiness, slurred speech stupor	Inhaled